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**VA HEALTH CARE DELIVERY FACILITIES
IN THE GREAT LAKES REGION**

HEARING
BEFORE THE
SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE
OF THE
COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES
NINETY-EIGHTH CONGRESS

FIRST SESSION

JULY 7, 1983

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VA HEALTH CARE DELIVERY FACILITIES IN THE GREAT LAKES REGION

THURSDAY, JULY 7, 1983

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9 a.m., in the auditorium, building 9, Edward Hines, Jr., Veterans' Administration Hospital, Fifth Avenue and Roosevelt Road, Hines, Ill., Hon. Robert W. Edgar (chairman of the subcommittee) presiding.

Present: Representatives Edgar, Evans, Rowland, and Hammer-schmidt.

Also present: Representative Simon of Illinois.

OPENING STATEMENT OF CHAIRMAN EDGAR

Mr. EDGAR. The Subcommittee on Hospitals and Health Care will come to order.

I am Congressman Bob Edgar, chairman of the subcommittee. I am pleased to be in the Chicago metropolitan area to hold these hearings.

On behalf of the subcommittee, I wish to welcome each of you to this oversight hearing on the VA's health care delivery facilities in the VA's Great Lakes Region as represented in the Metropolitan Chicago and surrounding areas. This is the second of six such oversight hearings the subcommittee plans to conduct during the 1st session of the 98th Congress. In each of the oversight hearings, we will hear from the Director of the VA Medical Region.

This morning we will not receive testimony from the Directors of the VA medical facilities in the area, inasmuch as we will be visiting three hospitals and one Vet Center this afternoon and throughout the day tomorrow, as well as the Department of Medicine and Surgery's Verification and Development Center. It was our feeling that it was unnecessary for the Directors to testify when we would be visiting them later.

I would be remiss if I did not note the excellent attendance at this oversight hearing by members of the Subcommittee on Hospitals and Health Care. For the record, I would like to introduce each of the members present this morning.

It is unusual for the subcommittee to get the participation in a hearing outside the city of Washington to the extent that we have this morning. I want each of the members to know I personally appreciate their attendance and their participation.

The Honorable Harold Washington, the mayor of the city of Chicago, as well as the entire Illinois congressional delegation, were invited to be with us this morning, but due to their busy schedules were unable to be here, with the exception of Congressman Paul Simon, who will join us in a few minutes.

This series of oversight hearings is particularly important at this time due to the crossroads that the VA health care delivery system faces over the next 5 to 6 years in providing quality and quantity medical services to eligible veterans. In the four VA medical centers in Medical District 17, there has been allocated in the current fiscal year almost \$300 million and 7,838 employees to provide health care to eligible veterans. The metropolitan area serves 994,000 veterans. By 1990, it is estimated that this figure will decline to 900,000 veterans. However, over the same period the number of veterans 65 years of age or older will increase nearly twofold to 24 percent of the population.

Nationwide, the VA has estimated that demands placed on the medical system due to increasing numbers of aging veterans will triple in the next 10 years. By 1990 alone, more than one-half of all American men over the age of 65 will be veterans.

Right now, due to the significant unemployment in the area, more and more veterans are coming to the VA for the first time. These facts indicate that we not only have a present problem but a future problem in maintaining the quality and quantity of care. The rapidly advancing age of veterans not only places a heavy demand on the VA for nursing home care, but also for hospital care resulting from acute episodes of chronic illness in the older veteran. We must cope with the present demand, but most important, we must be prepared to accommodate the future demand on the system as well.

We must also be alert to respond to the unique and changing needs of many other segments of the veteran population. For instance, we must address the continuing serious readjustment problems faced by thousands of Vietnam-era veterans. Yet another example is meeting the medical needs of those veterans deeply concerned about the effects of exposure to the defoliant agent orange. Likewise, we must provide medical assistance to those concerned veterans who were exposed to nuclear radiation during atmospheric atomic testing. Additionally, the Veterans' Administration medical system must remain compassionate and flexible in delivery of health care to eligible veterans.

The House Committee on Veterans' Affairs is, in my view, the most bipartisan committee in the U.S. Congress. Having said this, however, I do not believe that veterans' organizations and individual veterans can sit back and do nothing. The VA's health care and other benefit programs have been enacted by the Congress as the will of a grateful nation for the sacrifices these veterans made in serving in the Armed Forces of the Nation. But apart from that, the American people as a whole have greatly benefited from the investment in VA services and facilities. The VA medical budget for fiscal year 1984 is approximately \$8.1 billion. However, that figure represents only 2.5 percent of all national health care expenditures. At the same time, the VA has provided part of the training through its affiliations with the private medical communi-

ty. More than one-half of all health care professionals in the United States have been trained by the VA.

The medical research program has been responsible for finding a cure for tuberculosis, developing the cardiac pacemaker, as well as major breakthroughs in kidney transplants, cancer research, renal disease, hypertension and psychiatry, to name only a few. The four Chicago area medical centers have been allocated over \$7 million for VA-funded research. The VA is the Nation's largest health care provider with 172 strategically located hospitals and 226 outpatient clinics serving as the primary backup to the Department of Defense medical system in time of war or national emergency. The investment made in the VA is more than returned in kind.

Another reason for this hearing and the site visits to the three medical centers is to learn, first hand, the present condition of construction, maintenance, and repair of the veterans' facilities. This will give us some idea on which to build a solid base to provide quality health care to eligible veterans in modern health care facilities. In this regard, there are several construction projects in the pipeline that will affect these medical facilities. These are:

One, a \$10 million project for 120-bed nursing home care addition here at the Hines facility; second, a \$7 million 40-bed long-term spinal cord injury unit at this Hines facility; third, a \$44 million project to provide a 180-bed psychiatry facility replacement here at Hines; fourth, a \$36 million outpatient addition and renovation at the West Side facility; and fifth, a \$48 million series of environmental improvements in patient and nursing home care buildings at the North Chicago facility.

Funds for the first project were requested in fiscal year 1982. Funds for the project at the West Side VA Medical Center have been requested for fiscal year 1984, and the remainder to come in following fiscal years. In addition, the Congress, responding to disastrous unemployment rates across the country, approved the emergency jobs appropriations bill, H.R. 1718. That legislation earmarked \$4.6 billion to stimulate employment throughout the United States. I offered an amendment to the legislation, now Public Law 98-8, which targeted and restored over \$1 billion to be used for public works jobs and which targeted this assistance specifically for areas of high unemployment.

The so-called Edgar amendment was designed to provide additional employment opportunities particularly in the distressed industrial areas of the Northeast and Midwest. It does not take a crystal ball to realize that the greater Chicago area, with an unemployment rate of 10.8 percent in April, has qualified as a high-density unemployment area for jobs through maintenance and repair of VA medical facilities. All four of the VA hospitals in the area will share a part of those job-producing funds. This medical district will receive \$2.6 million for 17 maintenance and repair projects in this region.

Again I would like to thank all of the members and witnesses who are participating in the hearing this morning, and the VA employees who have provided invaluable assistance in making the hearing possible.

Now I would like to go back and introduce each of the Members here. Let me save the ranking Republican for last, who has an opening statement.

I would like for all of you to meet Lane Evans, who is a freshman Member of Congress, the only Member from the Illinois delegation to serve on the House Veterans' Affairs Committee. Lane, only being in Washington for 6 months, has distinguished himself by being the author of legislation which passed the House to extend for 3 years the readjustment counseling centers.

Also with us this morning is Dr. Rowland. Dr. Rowland is a freshman member of our committee as well. He is the only physician who serves on the House Veterans' Affairs Committee. He came to us from the State of Georgia and we are really pleased to have his expertise with us, not only at these hearings but on the full House Veterans' Affairs Committee.

Finally, I would like to introduce my colleague from Arkansas, the Honorable John Paul Hammerschmidt. John Paul is the ranking Republican on the House Veterans' Affairs Committee, and over the last 9 years that I have served in the House he has distinguished himself both on the Veterans' Affairs Committee and on the Public Works and Transportation Committee on which both of us serve. John Paul has been an active advocate for veterans benefits for many, many years, and I yield to him at this time for his opening statement.

STATEMENT OF HON. JOHN PAUL HAMMERSCHMIDT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARKANSAS

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman.

First may I congratulate you on scheduling this series of field hearings for our Subcommittee on Hospitals and Health Care. Such hearings give our members an insight into the VA medical care program which we simply cannot obtain by viewing that program only from the Washington scene.

Mr. Chairman, you have outlined the parameters for our 2-day visit to this area. You have also made reference to several basic medical issues facing the veterans of our Nation. Issues such as the medical needs of the aging veteran must command our attention now if we are to adequately prepare for the future. That future, even now, is almost upon us.

Mr. Chairman, perplexing issues face our committee in many other fields. The Department of Medicine and Surgery is just now really entering the vast field of computerization. For far too long it debated the route it would take. Fortunately, under the leadership of its new Administrator, Mr. Harry Walters, the VA is now moving rapidly ahead. Hopefully we will see evidence of this as we visit the four facilities in this area.

Mr. Chairman, it ought to be noted that the Paralyzed Veterans Association got much of its impetus back in the forties from the spinal cord injury unit at the Hines VA Hospital. As a matter of fact, I understand that PVA's first organizational meeting was held here in Illinois. Spinal cord treatment programs still have a long way to go, but it needs to be noted that the VA has come a considerable distance, and certainly the paralyzed veterans of this area

and the Hines people with whom they have worked need to be congratulated for their leadership and for their progress. In this connection I note that the chapter director of the Vaughan chapter of PVA is one of our witnesses this morning and I look forward to hearing his testimony.

Mr. Chairman, as I stated in the earlier press conference we were in, the Chicago metropolitan area is a reflection of the entire veterans program in our country. Here are four hospitals, deans committees, affiliations with medical schools, research, construction, a regional office, a computer center, a supply depot, and three vet centers.

This area serves thousands of veterans and dependents and employs thousands of people. Moreover, this area is a stronghold of each of the major veterans' organizations and their auxiliaries. The service officers of these organizations are excellent, as are the representatives of the Illinois Veterans Commission who work closely with them. We couldn't come to a more concentrated veterans area for this hearing and tour.

I congratulate you again, Mr. Chairman, for the well laid plans. I am delighted to be here with my other colleagues, especially Lane Evans from this area, and certainly Dr. Rowland, our colleague from Georgia, who really adds expertise to this area because he is an M.D. and did general practice for many years. I am delighted to be here with them.

I look forward to hearing our distinguished witnesses and visiting with the officials of the hospitals here in Chicago.

Thank you very much, Mr. Chairman.

Mr. EDGAR. Thank you, Mr. Hammerschmidt.

I would like to yield now at this time to Lane Evans for an opening statement.

STATEMENT OF HON. LANE EVANS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. EVANS. Thank you, Mr. Chairman.

I just want to say that my hat is off to you and John Paul and Roy Rowland for coming here today. I know it is an important time to be back in your districts during the district work period. I appreciate you taking the time.

I will shortly be introducing a constituent of mine, Miss Lori Johnson of Moline, Ill., to talk about her personal experiences with post traumatic stress disorder, and I appreciate the opportunity not only for myself to participate but for the committee to allow a witness from my community to participate in these hearings as well.

Thank you very much, Mr. Chairman.

[The prepared statement of Congressman Evans appears on p. 65.]

Mr. EDGAR. Thank you.

Dr. Rowland, do you have any opening comments you would like to make?

STATEMENT OF HON. J. ROY ROWLAND, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Dr. ROWLAND. Thank you, Mr. Chairman.

I am delighted to be in the great State of Illinois today, and I do appreciate you calling this hearing, and also the ranking member of the entire Veterans' Affairs Committee, Mr. John Paul Hammerschmidt, and my good friend and colleague, Lane Evans, in his home State.

The problems are growing increasingly complex, as you pointed out. We are finding there are some areas of latent activity that are coming to the forefront now, the atomic veterans and exposure to ionizing radiation, plus exposure to dioxin. We don't know just what all this portends for the future, and I am looking forward to learning more about this.

Thank you very much for the opportunity to be here.

Mr. EDGAR. Thank you.

Without objection, all opening statements will be made a part of the record at this point. Before we proceed, I would like to express my sincere thanks to all of those who participated in making these hearings possible, particularly this morning's hearing, as well as the on-site tours we will be making over the next 2 days.

It was determined that we would not just come and listen to people given prepared remarks, but we would actually go out and see and sense for ourselves exactly what the health care network is. It takes a lot of preparation and we do want to thank all of those who participated.

I want to give special thanks this morning to the veterans' organizations and the volunteers who have provided a welcome to us this morning, providing us with some refreshments this morning, as well as lunch this afternoon.

We will now move to our first panel of witnesses. I would ask Mr. Al Zamberlan to come to the witness table, and he will be joined by Mr. Donald L. McGee, the Director of the North Chicago Veterans' Administration Medical Center; Mr. Joseph Moore, Director of the Lakeside facility; Mr. Alvis Carr, Director of the Westside facility; and Mr. John Fears, Director of the Edward Hines, Jr. facility.

Gentlemen, we appreciate your coming this morning and participating in these hearings. Mr. Zamberlan, we welcome you to the hearing this morning. We have decided to have each of our six field hearings begin with a statement from the regional director of the health care region, and we are pleased that you have come to share your remarks and following your remarks we will be prepared to ask some questions.

The full text of your statement will be made a part of the record.

STATEMENT OF AL ZAMBERLAN, REGIONAL DIRECTOR, GREAT LAKES REGION, DEPARTMENT OF MEDICINE AND SURGERY, VETERANS' ADMINISTRATION, ACCOMPANIED BY DONALD L. MCGEE, DIRECTOR, NORTH CHICAGO VAMC; JOSEPH L. MOORE, DIRECTOR, CHICAGO (LAKESIDE) VAMC; ALVIS B. CARR, JR., DIRECTOR, CHICAGO (WESTSIDE) VAMC; AND JOHN R. FEARS, DIRECTOR, HINES VETERANS' ADMINISTRATION HOSPITAL

Mr. ZAMBERLAN. Mr. Chairman, members of the subcommittee: We appreciate having you join us today in Medical District 17. The primary mission of every VA Medical Center is the provision of the

highest quality health care to our Nation's veterans. We in the Great Lakes Region are committed to this mission, though we recognize as well the additional imperative of offering quality services in a cost-effective environment.

Four medical centers—the Edward Hines, Jr. Hospital and the Lakeside, North Chicago, and Westside VA Medical Centers—comprise Medical District 17, which is the most complex medical district in this region. Four medical school affiliations, urban economics, and a full spectrum of health care are among the factors which have given Medical District 17 a distinctive profile. As will be discussed further, perhaps no other configuration of VA medical facilities in the country better exemplifies the system's strengths and vulnerabilities.

Today, the Metropolitan Chicago medical centers serve a population of over 994,000 veterans who reside in 17 northeastern Illinois and 6 northwestern Indiana counties. Thirty-six percent of this population is under 45 years of age, while 14 percent is over age 65. By 1990, the estimated veteran population will decrease by 10 percent to around 900,000. The portion of veterans over age 65, however, will increase nearly twofold to 24 percent of the population. Approximately 36,000 female veterans currently reside in the Chicago primary service area and were responsible for 455 discharges during fiscal year 1982.

The four Chicago medical centers have a total complement of 3,830 authorized beds which includes 430 VA nursing home beds. The 7,838 Full-Time Employment Equivalent [FTEE] employees include 1,272 FTEE registered nurses and 392 FTEE physicians. Medical school affiliations increase physician staffing levels by 438 house officers. Medical District 17 is fortunate at this time to have minimized any nurse recruitment and retention concerns.

Workload and productivity measures show the Chicago medical centers to be among the most active in the system. Overall, the hospitals maintain an occupancy rate above 80 percent with one facility averaging close to 90-percent occupancy. The total number of patients treated in the first 8 months of this fiscal year is over 36,000 for the four hospitals. 467,000 outpatient visits were accomplished during the same 8-month period. Noteworthy is that the patients treated and outpatient visits are exceeding planned levels by nearly 8 percent. The medical district is current in the processing of agent orange examinations and has appointed a physician coordinator for the POW health assessment program.

The fiscal year 1983 medical care budget for Medical District 17 is just under \$300 million. In addition, the four medical centers have over \$7 million in VA-funded research. These programs include significant initiatives in medical, rehabilitation, agent orange and health services research.

This fiscal year the medical centers will accomplish projects totaling \$6.2 million in the nonrecurring engineering maintenance and repair program. In addition, \$2.6 million in jobs bill funding will support another 17 M&R projects in the district.

The Chicago area hospitals continue to be recognized as among the most progressive medical centers in both the region and the agency. For example, the Hines VA Hospital has been in the forefront of the Department of Medicine and Surgery's decentralized

ADP initiative and has been designated as a verification and development center. Hines also has a proud history in rehabilitation delivery programs. Reflecting this are two distinguished programs—spinal cord injury and blind rehabilitation. The district's strategic planning process, MEDIPP, identified the increasing importance of special services for the aging veteran. Recent accomplishments in geriatrics already include the activation of a new nursing home care facility at Hines, a locally acclaimed senior adult center at North Chicago, and the participation of the Lakeside VA Medical Center in a new interdisciplinary center on aging at the McGaw Medical Center.

The role of Medical District 17 in the utilization of sharing legislation has been significant. It is our belief that the implementation of Public Law 97-174 which authorized VA/DOD sharing will enhance sharing opportunities because of the incentives dealing with reimbursement availability at the local level. Under the existing sharing legislation, an agreement between the North Chicago VA Medical Center and the Great Lakes Naval Regional Medical Center covers services such as laboratory and radiology. Sharing of additional services is currently being pursued.

The Medical District 17 track record, both in delivering patient care services and participating in new programs and initiatives, has been sustained through conscientious management and adequate resources. Future successes, however, are dependent on the district's ability to meet and overcome the challenges of an eroding resource base. The issues are not only budgetary but also include the dilemmas caused by pervasively poor economic conditions throughout the Great Lakes Region, facility aging and structural obsolescence, and the specter of the return of recruitment and retention concerns in the Federal work force. In response to these challenges, the region has been a leader in the development and testing of new casemix-oriented resource allocation methodologies. These formulas are designed to stimulate management efficiency and to consider the acuity, as well as the quantity, of care rendered.

Improved sensitivity in the allocation of recurring funding, however, will address only one set of issues. Nonrecurring renovation and construction projects are also critical to the future of the VA's health care delivery system. In Medical District 17, for example, significant clinical improvements are being planned for the next several years and include such projects as a \$10 million, 120-bed nursing home care addition at Hines; a \$7 million, 40-bed long-term spinal cord injury unit at Hines; a \$44 million, 180-bed psychiatry facility replacement at Hines; a \$36 million outpatient addition and renovation at Westside; and a \$48 million series of environmental improvements in patient and nursing home care buildings at North Chicago.

The age of many of our facilities—some in this region date back to the Civil War—preclude their adaptation for new technologies. In some instances, their condition falls below the desired life safety code standards for patient care. Unfortunately, outdated facilities may confound delivery system efficiency and ultimately compromise the quality of care.

Finally, while MEDIPP has given us the tools to predict future demand based on demographic data, we have no tools to predict future demand influenced by economic trends. The Great Lakes Region has been perhaps the hardest hit by unemployment and its consequences. Informal studies conducted this winter and spring here in Chicago show a steady and significant increase in new consumers in the VA system. One hospital reports that as many as 30 percent of its applicants have not utilized VA health care services in the past 3 years and may never have used VA services. We believe that many of our new consumers are unemployed, and now uninsured, veterans who previously received their health care in the private sector. State reductions in Medicaid funding and pending changes in the Medicare reimbursement structure as defined by Public Law 97-248 and regulations subsequent to the Tax Equity and Fiscal Responsibility Act may be encouraging private sector providers to instruct individuals to utilize their veteran benefits. We are continuing to study more rigorously the extent of consumer influx; however, the full impact of the economy's shifts will remain difficult to assess.

In concluding my remarks, I wish to express my appreciation to the subcommittee for this opportunity to discuss the Veterans' Administration health care system in Medical District 17. We in region 4 look to the future confident that we will be able to continue to deliver high quality services to our veterans. As managers, we view the challenges as pathways to innovation and improved performance. We are proud of our medical centers, our dedicated staffs, and our volunteers, and we welcome you to Chicago.

This concludes my statement, Mr. Chairman. My colleagues and I will be pleased to respond to any questions that you or members of the subcommittee may have.

[The prepared statement of Mr. Zamberlan appears on p. 66.]

Mr. EDGAR. Thank you, Mr. Zamberlan.

Let me just ask some basic questions first. Can you give me a definition of what a Regional Director is, what his job is?

Mr. ZAMBERLAN. The Regional Directors look upon ourselves as extensions of the Chief Medical Director's Office. We are line officials and I have supervisory authority over 25 medical centers in region 4.

Mr. EDGAR. There are 25 medical facilities that you have jurisdiction over?

Mr. ZAMBERLAN. Yes, Mr. Chairman.

Mr. EDGAR. Where is your office located?

Mr. ZAMBERLAN. I have an office in Washington with a staff there, and I have a field office in Ann Arbor, Mich.

Mr. EDGAR. And it is out of that field office that you do most of your field visits, or do you do that from the location in Washington?

Mr. ZAMBERLAN. I do most of my field visits out of Ann Arbor. My staff in Washington and Ann Arbor does field visits, also.

Mr. EDGAR. From your testimony you point out that there has been a significant increase in the number of veterans who are using the facilities for the first time, many of those veterans who would have traditionally used their own private medical insurance

but because of high levels of unemployment are now using the VA facility.

Can you give some more detail about the number of people who are using the VA facilities who you see as new, first-time users who may be coming because of high rates of unemployment?

Mr. ZAMBERLAN. Yes, I can give you a regional overview, and I'll ask some of the directors to be more specific.

As you know, the Midwest States were hard hit by unemployment. We are finding more people who indicate they are unemployed, and consequently, have lost their health benefits.

In fact, in one of our medical centers here in Chicago, we ask each veteran applicant that question as he applies. Thirty percent state that principally it is because of unemployment that they have lost their insurance coverage, and they are using their VA eligibility for the first time.

Mr. EDGAR. Perhaps your directors of the health care facilities would want to answer this question.

How are you meeting this increased load within your facilities without an increase in personnel and staffing and funding?

Mr. ZAMBERLAN. Let me give you a general overview, and then I would like to have the directors provide more insight into this issue.

First, Mr. Chairman, what is happening, is that we are diverting our nonrecurring resources to support recurring needs. For example, the allocation of resources for equipment and M&R projects, not all of them, but some of them, are being diverted to actually support our recurring base.

Second, because of the increased costs in what we call all other recurring costs; supplies, drugs, et cetera, we are less able to support the number of recurring FTE that we had planned. Third, we are depleting our inventories, shelf stock, hoping to rebuild them next year. So through the support of less personnel, and also diversion of nonrecurring dollars, and inventory depletion, we are surviving at the present time.

Mr. Chairman, I would like to have Mr. Fears respond more specifically.

Mr. FEARS. At Hines, for example, the amount of money we are spending for pharmaceuticals is approximately \$350,000 per quarter more than we planned when we put our budget together. This sort of dollar allocation, dollar amount, is very difficult to obtain when the pot is dry. So basically what we do is rearrange our priorities within the center and put the dollars where the patient care is.

I think the most important thing is, when you ask that sort of question, I take great pride in the fact that the employees at this center just put their nose to the grindstone and buckle down and do the best they can. It is almost a superhuman effort sometimes to deliver quality care. We have had approximately a 15 to 20 percent increase in the number of applicants who have walked in the door, with a flatline staffing. The only way that sort of work is taken care of is just through good hard work and dedication by the employees.

Mr. EDGAR. Do you have any projections on how many people you have to turn away from this facility, or are you not confronted with that problem?

Mr. FEARS. At this point we have not had to turn anybody away from this facility.

Mr. EDGAR. Mr. McGee.

Mr. MCGEE. I would concur with John's remarks. Probably at hospitals, particularly of the size of North Chicago, which require so much nonrecurring moneys, moneys to repair buildings and to keep buildings painted and minor repairs that keep the buildings in shape—since our buildings are dated from about the 1920's—those moneys just have to be diverted to any increases in the cost of pharmacies and the ancillary costs that come in to outpatient care.

Mr. EDGAR. Mr. Moore or Mr. Carr, do you have anything to add in terms of the problem?

Mr. MOORE. Mr. Chairman, I would only add that there are many external accrediting bodies that come to our facilities. They look at us in terms of how we measure against the private sector. What invariably happens when there is not enough resources to be distributed to take care of our patients, then, in fact, those things suffer. As far as I'm concerned, that has to take second place before we turn patients away.

Again, I would concur with my colleagues, in that we very frequently defer M&R projects or equipment replacement. These are the problems we are faced with when funding is inadequate and our patient load or demand increases.

Mr. EDGAR. Mr. Carr?

Mr. CARR. I would concur with everything that has been said. I will not reiterate it.

But to give you something in terms of the order of magnitude, our pharmacy deficit this year at the Westside Medical Facility is going to approximate \$700,000. We have had to make this up by a continuing erosion of personnel funding and by diverting the greater part of the capital equipment program for this fiscal year. We won't know until the fourth quarter is halfway through just how much of that is going to have to be diverted.

We have received some assistance from the Regional Director in terms of the realignment of funds within the region. That has brought some relief.

I think the problem can be pointed up by this fact: We have a burgeoning workload demand and a shrinking resource dollar and FTEE. If you project those lines out, it spells a very, very serious situation.

Mr. EDGAR. Let me ask a question in another area—and I have additional questions that I will come back to after this question and after my colleagues have had a chance to ask some questions.

Several years ago I came to the northwest Indiana area and participated in a hearing to determine the need for a clinic because of the problems of transportation to the Hines facility. I understand that after the hearings were held—and these hearings were supported and pushed by our late colleague, Congressman Adam Benjamin—that, in fact, a clinic has been established in that area.

For the record, Mr. Zamberlan, would you give the subcommittee a review of the VA's action to date to meet the need of that clinic facility, and also could you indicate to the committee how the decision was made in terms of location of that facility?

Mr. ZAMBERLAN. Yes, Mr. Chairman. You are indeed right. A decision has been made. I testified at a hearing that you held in Gary, Ind., in December 1981.

There are around 160,000 veterans that are underserved in northwest Indiana. It is difficult, as was pointed out in your committee hearing, for people to travel from that part of Indiana into Chicago because of the time it takes and because of the traffic congestion. Because of this, we decided that we did require a clinic in northwest Indiana.

Our Administrator, Mr. Walters, has selected the site of Crown Point. I fully support his decision. It is immediately adjacent to Gary, Ind. In fact, several members of my staff and I visited the area yesterday. The location is transportationally accessible to the veterans who will be utilizing it. At the present time, we are reviewing alternative sites. We are projecting an annual workload of 50,000 visits, and that would approximate the requirements of 100 additional staff to our budget.

Currently we are looking at starting the design phase of construction by April 1984. We hope to occupy the structure in early 1986.

Mr. EDGAR. Thank you very much.

I have additional questions but I will hold off for a few moments on those questions.

Let me yield at this point to my colleague, John Paul Hammerschmidt.

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman.

First of all, Mr. Zamberlan, I would like to compliment you and your staff and the hospital directors and all the VA doctors and nurses and employees of the Great Lakes Region. Judging from your testimony and the other materials I have studied, the Great Lakes Region is executing its responsibilities in an exemplary fashion, so I want to congratulate you and all the other employees for the fine work, and I look forward to your continuing consultation and collaboration. As you know, this committee always invites you to treat us as a willing ear to any and all problems and suggestions you may have. We need to hear from you as to the future if we are to execute our responsibilities properly.

You mentioned that Medical District 17 has minimized nurse recruitment and retention concerns. Since other medical regions and districts have sometimes not been so fortunate, I wonder if you could share with us some of the apparent keys to your success in this area.

Mr. ZAMBERLAN. I think it really has taken a lot of hard work on the part of the medical center directors, chiefs of nursing service, and their recruiting personnel. And I will give you some statistics that will reflect this.

In 1980, our turnover rate for registered nurses averaged 30 percent for the four medical centers. During fiscal year 1983, that figure has dropped to approximately 13 percent. This is below the

national average and is acceptable. We do not have many vacancies.

Part of our success has come at the sacrifice of some of our private sector hospitals. They are not able to afford the staff they did before because of the reductions in medicaid and medicare funding. There are more nurses that are recruitable to us because our private sector counterparts cannot afford them.

One other very important thing is by reducing the recruitment and retention efforts, we are able to improve the quality of nurses. At one time we had a large number of foreign graduate nurses who had communication problems.

Mr. HAMMERSCHMIDT. I note that in terms of outpatient visits and the number of patients treated, Medical District 17 is exceeding planned and anticipated levels by almost 8 percent. How are you coping with the obvious budgetary concerns this 8 percent figure represents?

Mr. ZAMBERLAN. As I indicated earlier, Mr. Congressman, we are diverting—and we have been doing this year to year—some very meaningful dollars from capital investments, such as equipment and construction nonrecurring resources, to support our recurring base. In addition, the number of employees we planned to recruit and retain will be reduced because we will also have to divert personal service dollars to support all other recurring requirements. Finally, we are depleting our inventories.

Mr. HAMMERSCHMIDT. Our chairman mentioned the outpatient clinic planned at Crown Point, and I, too, want to remember fondly our departed colleague, Adam Benjamin, who was one of the great Members of Congress. He did tremendous work for the country and the Congress misses him.

I would just mention that one of our colleagues from Indiana, who is third ranking on the Republican side of the House Veterans' Affairs Committee and who is ranking on the Oversight Subcommittee, is talking with the members of the Indiana delegation and I know plans to introduce a bill to name that outpatient clinic after Adam Benjamin. I would just bring that out as a matter of information. I think is very appropriate for them to do so.

I wonder, Mr. Zamberlan, if you could briefly outline some of the major projects which are being funded in this region as a result of the passage of the recent jobs bill?

Mr. ZAMBERLAN. I could not identify them specifically at this time. I would be very happy to provide the list for the record.

Mr. HAMMERSCHMIDT. All right. If you would, I think it would be a valuable part of the testimony.

[Subsequently, the Veterans' Administration furnished the following information:]

REGION 4—JOBS BILL PROJECTS

Outline of some of the major projects in Region 4:

MEDICAL DISTRICT 13

Concrete/Asphalt Pavement Repairs, Replace New Ceiling Tile, Replace Roofs, Replace Windows, Street Repair, Additional Smoke Detectors.

MEDICAL DISTRICT 14

Paint Wards, Parking Lot Improvements, Rewire Buildings, Install Handrails on Patient Wards, Replace Roofing, Street Repairs.

MEDICAL DISTRICT 15

Replace Storm Drainage, Exterior Painting, Handicap and Safety Handrails, Replace Windows, Road Repair and Paving, Waterproof and Tuckpoint Buildings, Replace Sidewalk.

MEDICAL DISTRICT 16

Remove Asbestos, Replace Windows, Security Alarm System, Thermal Windows, Replace Freight Elevator.

MEDICAL DISTRICT 17

Renovate Toilet Bath and Restrooms, Renovate Medical Sciences Building Systems, Replace Corridor Ceiling and Lights, Reroof Buildings, Asbestos Removal.

MEDICAL DISTRICT 21

Replace Roof, Replace Storm Sewers and Landscape, Replace Floor Tiles, Replace Windows—11 Buildings, Replace Automatic Door—Main Entrance, Install Thermostatic Controls

Mr. HAMMERSCHMIDT. Since we will be visiting the Great Lakes Naval Center tomorrow, I would like to have you outline some of your plans for additional sharing of services with that facility in light of Public Law 97-174, the VA/DOD sharing law.

Mr. ZAMBERLAN. I would like to mention just several, and then I would like to ask Mr. McGee to amplify on the remarks I make.

We have had several sharing agreements with them, and, as I indicated in my prepared statement, we do have a program involving laboratory and radiology services. Also we did look at the sharing opportunity of utilizing some of their inpatient beds when some construction programs decreased our in-patient bed capacity. We continue to pursue sharing opportunities vigorously, and I would like to ask Mr. McGee to comment at this time.

Mr. MCGEE. We have been discussing sharing for quite a number of years, dating back even to the Executive order from Calvin Coolidge on sharing beds. The Navy does provide us with important services and utilities. They provide us with steam, electricity, fire protection, trash pickup, some M&R help.

In the way of the medical hospital, we are working on agreements and are providing radiation, oncologists, gastroenterologists, laboratory tests, and renal biopsies. We are entering into an agreement on corpsmen training, with those medical corpsmen over at the Navy coming over and getting part of their training at our place, and also getting the help that comes with that.

The Navy has been providing us with blood and blood products at substantial savings. Radiation therapy equipment they furnish, and they also do some laboratory tests for us.

Mr. HAMMERSCHMIDT. Mr. McGee, that facility lays right alongside your facility there at North Chicago, is that right?

Mr. MCGEE. The Navy facility is less than 1 mile away.

Mr. HAMMERSCHMIDT. Do they share with the other hospitals as well, or just with North Chicago?

Mr. McGEE. I'm not really familiar with what the Navy may do with some of the others. I know they do utilize the VA at other places other than mine, particularly over at Milwaukee.

Mr. HAMMERSCHMIDT. Mr. Moore, do you do any sharing with them?

Mr. MOORE. No, sir.

Mr. HAMMERSCHMIDT. Mr. Fears, do you?

Mr. FEARS. Yes, sir; we do furnish some services to the Navy. For example, on several occasions we furnish CAT scan capabilities for them in emergencies.

Mr. HAMMERSCHMIDT. Mr. Carr, do you?

Mr. CARR. No, sir.

Mr. HAMMERSCHMIDT. Well, Mr. Chairman, I will forego any further questions. I am sure my time is up. I notice the entry of one of our very distinguished colleagues here and I am sure you will want to introduce him.

Mr. EDGAR. Thank you.

Before I introduce my colleague, Mr. Zamberlan, are all the members of your panel able to stay for most of the hearing this morning?

Mr. ZAMBERLAN. Yes, sir; all the members of the panel will be available for the entire hearing.

Mr. EDGAR. I wonder if I could ask you to take your seats and come back again in a few minutes. We have some pressure of time and we have one colleague to introduce, and also a witness who has time pressure. Also, one of our colleagues must leave. So if you would be courteous enough to step aside for a moment while we handle this one little problem, then we'll get back to you.

I would like to ask one of our witnesses, Mrs. Lori Johnson, to come forward. She is a member of Quad City Vietnam Veterans, Inc.

While she is coming forward to take her place, I would like to introduce to all of you Congressman Paul Simon from Illinois who has been able to join us this morning. Before recognizing Congressman Simon, I would like to indicate that in two specific areas Congressman Simon has been an outstanding Member of Congress in his commitment to veterans' concerns.

A year ago I joined with him in working to repeal a provision of law which was complicating the opportunity for veterans, particularly of the Vietnam-era, from receiving Pell grants. A very technical change occurred where the Education Department was using GI education benefits in computation of Pell grants and most people were being disqualified in eligibility of any Federal education assistance. But, through the help of Congressman Simon, we were able to pass some legislation repealing that law and providing an opportunity for veterans to qualify for those Pell grants.

More recently Congressman Simon testified before the full Veterans' Affairs Committee's Oversight Subcommittee dealing with the issue of atomic veterans. His concern and the legislation that he has introduced would provide compensation for those atomic veterans. Last week I was able, through the help of my colleagues, to pass a resolution out of the House and out of the Senate, sending it to the President's desk, to recognize July 16th as National Atomic Veterans Day. That is the 38th anniversary of Trinity, which was

the first atmospheric test of an atomic weapon. We have discovered that some 250,000 veterans were exposed to nuclear radiation through their presence at those atmospheric tests. His leadership in that area is to be commended.

So, Congressman Simon, we are pleased to have you here. If you have any opening comments you would like to make, please do so at this time. Then we will hear from our witness.

Mr. SIMON. I shall be very brief. I appreciate the opportunity to be on this panel. I don't claim the distinction of being on this subcommittee, but through their tolerance I am up here.

I appreciate the leadership that you and the other members of this subcommittee are providing, and I appreciate the good work of the VA. We have a hospital in my district at Marion that we are very proud of.

I would add, as long as I can lobby you and the VA officials at the same time here, I would add that I am increasingly running into veterans who are having nonservice-connected disabilities and are having a really tough time of it, who are not getting the kind of help that somehow we ought to be giving. I am in an area of very high unemployment, where people have major economic problems, and one way or another, it seems to me we ought to be providing greater assistance for these veterans.

Then the other area that you touched on, Mr. Chairman, that I think that Congress as a whole, and the VA also, has to recognize we have a special problem, and that is those who were exposed during the first testings of the bombs, when we did not know what damage was being done. If I can use this one illustration of a gentleman in my district, Bob Farmer, who like many who were there, has developed thyroid cancer. The rate of thyroid cancer is about six times as great as with the general population. He and his wife have nine children, eight of whom appear to be perfectly normal at birth—one had a deformity. But as it has turned out, all nine have developed some kind of genetic deformity. Neither this veteran nor his wife has any family history whatsoever of anything like that.

I think we have to recognize that these veterans and their families deserve a little greater protection than they are now being given.

I am sure my colleague, Lane Evans, has welcomed you to Illinois, but let me just add we are pleased to have you here.

Mr. EDGAR. I appreciate that. We really appreciate your taking the time to be with us this morning and participating in these hearings.

I yield now to my colleague, Lane Evans from Illinois.

Mr. EVANS. Thank you, Mr. Chairman. I want to welcome Paul Simon to our committee and to the Chicago area. I have admired Paul Simon since I started in politics, and I particularly admire him for the introduction of his atomic veterans bill. My father was one of those people who, when in the Navy at Bikini Atoll, was exposed to a nuclear test blast. I am fortunate, in a sense, and he is fortunate, that he hasn't had severe side effects, at least to this point. But that is the kind of commitment that Paul Simon has that started from a constituent coming to him and talking about the problems that he had with atomic radiation. I think that is the kind of Congressman Paul Simon has been, somebody that has

taken an individual problem and turned that into legislation. I thank you for my father, Paul, for introducing that legislation.

Mr. SIMON. Thank you.

Mr. EVANS. I would like to introduce to the committee and to the audience here today Ms. Lori Johnson, a constituent of mine from Moline, Ill. She is an employee of the Western Illinois Legal Assistance Foundation in Rock Island, and is a member of the Quad City Vietnam Veterans, Inc., a Vietnam veterans organization in Rock Island. Ms. Johnson is starting a group of spouses and former spouses of Vietnam-era veterans. She is going to relate to us her personal story centering on the problems of a spouse who was married to two Vietnam veterans, in her particular instance and the problems that those husbands of her's had with post traumatic stress disorder. I think we quite often do deal with the veterans' side of these matters, but the spouses and sometimes the children of Vietnam veterans suffer as much from post traumatic stress disorder as do the veterans.

Lori, I would like to welcome you to the committee. I will mention to you that I know you have a lengthy statement and that it will all be incorporated into our record. In the interest of time, I would ask that you summarize that in about 5 minutes and stand by for questioning.

I have to mention that I will be able to stay for about 5 minutes of your statement—if I could maybe ask one or two questions, Mr. Chairman quickly, and then I have to leave for a plane, but I wanted to welcome you to the committee today.

Ms. JOHNSON. Thank you very much.

Mr. EDGAR. Ms. Johnson, if you could pull that microphone as close as possible to you.

STATEMENT OF MS. LORI JOHNSON, MEMBER, QUAD CITY VIETNAM VETERANS, INC.

Ms. JOHNSON. As Congressman Evans said, I am going to summarize my statement.

I have been married to two Vietnam veterans. The marriage increased my vocabulary, if nothing else. It gave me words like "delayed stress, blackouts, flashbacks, physical violence, metaphysical experiences." I am just going to go over a couple of them. Maybe I want to shock you, I don't know. I know these men need help.

I awoke one night to find the other half of our bed empty. After checking all the other rooms in our small apartment, I slowly opened the door to the room shared by my two children, Lisa, age 8, and Brian, 2½. The light from the hallway seemed to zoom in on a shiny object lying across my little girl's neck. As I opened the door further, I saw David on his knees next to the bed. The shiny object was a bayonet. David looked at me and smiled, and whispered, "Shhh, I got me a slope." I froze. I remember praying for guidance, and I even remember wondering how long it takes for a prayer to reach God and for Him to send an answer. I felt all the strength draining from my body. My legs went weak and I dropped to my knees. David motioned me to come to him with the wave of his arm. I crawled over to the bed, wondering if there might be a way I could get the bayonet without injuring my sleeping daughter.

"Here," he said, handing me the bayonet, "I've got to get the lieutenant. Keep an eye on him."

I took the weapon and I watched my husband crawl on his hands and knees out of the bedroom and up the hall. I sat on the floor and wept. My little boy, who had been sleeping in the top bunk, leaned over the side of the bed and said, "Mommy, why are you going to hurt Lisa?"

David crawled on into bed and was sleeping soundly. I spent the rest of the night sitting on the living room couch so I could have a clear view of both of the bedrooms. I sat with the bayonet laying on my lap. As the morning Sun started filling the living room, I looked at the blade of the weapon. Carved into it were the words, "Yea, though I walk through the valley of the shadow of death, I will fear no evil, for I am the meanest son-of-a-bitch in the valley."

My husband would sit with his buddies at Fort Carson and tell light, funny experiences about their time in Vietnam. He told me many times during our marriage that he would never talk about some of the things that had happened, and that there was one incident he would never be able to share with me. He said, "You would stop loving me if you knew what I did in 'Nam."

It was years later that I finally got a letter from him relating the experience—and this is it.

Ellis and me caught this little kid trying to steal food from our hootch. I had him by the neck and had my knife at his throat before Ellis yelled at me that it was just a kid. We stripped him naked to be sure he wasn't booby-trapped. Some of the guys wanted to waste him because kids were killers there, too. But I didn't think this kid was. They told me I could take him in, but I would have to be responsible. The kid had probably been on his own most of his life, living off the land, and one thing for sure was that he never learned how to use a latrine. One day the Sarg stepped in a pile of his crap and took Tye and rubbed his nose in it like a dog. It took weeks, but I taught the kid how to use the can. He worked cleaning the hootch for me and Ellis and we gave him food and clothes. All the guys teased me because the only words he could say in English were like "Davi-sun". I carved a rifle for him. Nights he would sleep on the floor next to my mat. One night he crawled out of the hootch to go to the bathroom. The next we knew we heard a shot. One of the guys was using the latrine, and when he came out he saw Tye but didn't know it was him. He called out for identification and Tye answered in Vietnamese and the asshole shot him. He said he wouldn't have shot if it hadn't been for that gun. I killed that kid just as sure as if I had pulled the trigger myself.

After my husband wrote to me and told me about this, he also filed for a divorce, because he was that sure that I could never love him again.

I was single again until 1981, and again married a Vietnam veteran, this time a retired "lifer." I knew he had had problems with stress. I knew he had gone through counseling.

The incident I want to relate in this marriage is flashbacks. It happened one night while I was watching television. Several weeks later he came home for one of his visits. He was sullen and moody all day. I left him alone. I decided to watch television until I knew he was asleep. Suddenly the door burst open and there he stood. His fists were clenched and pressed tightly against his sides. His eyes were black and he was breathing heavily, seething. He just stood there looking at me. Then he said, "You fucking gook. You killed my people."

Before I could move, he jumped on my chest and started choking me, all the while jumping up and down. I felt faint, then nothing. I

lost consciousness. When I came to, he was still sitting on my chest, but had my tongue pulled out of my mouth and he was burning it with his cigarette. He kept saying, "I'll teach you to talk, gook."

I was crying and he pulled back and looked at me in what I could only describe as amazement. Then he began to cry. He was shaking and sobbing. I said, "It's OK, it'll be all right."

He got off me and ran out of the house. It was days later before he called me. He remembered nothing of the incident and only that something terrible had happened.

The only ray of hope that I saw was when my husband became involved in a rap group in the Quad Cities. The problem a year ago was that there was no professional guidance. The men would sit and pour their guts out, but then have no place to go with the feelings that they had. The money had been allotted for a professional counselor within the area, but by the time he actually got the contract and began working, my husband had quit the group and said he could make it on his own.

In October I again sat in divorce court and listened to a judge telling me that my marriage had been dissolved.

Initially the group didn't trust me. I don't think they wanted me to stay with them. I think they thought I wanted to remain in the group to advocate divorce. I want to stay in the group in the hope that I can prevent this from happening to even one more person.

This is the end of my summary.

[The prepared statement of Ms. Johnson appears at p. 66.]

Mr. EVANS. Thank you, Lori. I appreciate your moving personal experience and relating that to us and your involvement in the Quad Cities Vietnam Veterans, Inc., which is the rap group you were talking about.

I think most people realize that the majority of Vietnam veterans have had a successful reintegration into civilian society, but I think your testimony indicates there are at least a significant minority that continue to have those kinds of post-traumatic problems.

Your group is a voluntary group——

Ms. JOHNSON. That's right.

Mr. EVANS [continuing]. And aided by a contracted-out local psychiatrist in the Quad Cities area.

Do you think it would be easier for a Vietnam veteran perhaps to go to the storefront in the Quad Cities or in Peoria and meet peers of his own, people that perhaps served in Vietnam, or at least Vietnam-era veterans that have a background not only in counseling for Vietnam veterans but specific training in counseling those persons with post-traumatic stress disorder?

Ms. JOHNSON. You can always relate to someone that you know has been through the same thing that you have. When Chris first called me and told me about the group, he was amazed. He said, "My God, I am not the only one going through this. There are hundreds of others." So the answer to your question is yes, it would be easier just because the comradeship is there.

But the storefronts alone are not enough. There has to be the professional medical help, because I have sat in on these meetings with the men and I have watched them walk out of the meetings

worse off than they were when they came in, because there was no place to go with the anger.

Mr. EVANS. I just want to say I appreciate your taking the time off from work today to come here and to tell us of your experiences. We talk about the numbers of people that come into the veterans centers, and those are significant numbers of people. But we don't always, when we deal with statistics, deal with the human side. The social costs are significant. Many veterans are not being served because of stretched resources within our veteran centers, and many wives and children also suffer because these veterans do not receive the treatment they deserve. We appreciate your coming today.

Ms. JOHNSON. Thank you.

Mr. EDGAR. Thank you, and thank you, Lane, for taking the time to come. We will join you a little bit later in our field hearings as you return to the subcommittee.

I would like to yield now to my colleague from Arkansas, Mr. Hammerschmidt.

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman.

Ms. Johnson, I have no questions. We are somewhat familiar with your story because our colleague, Mr. Evans, put part of it in the Congressional Record during consideration of a bill. I just want to express my appreciation to you for being here and giving the committee the benefit of your bad experience and your wisdom.

Ms. JOHNSON. Thank you very much.

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman.

Mr. EDGAR. I yield to my colleague from Georgia, Dr. Rowland.

Dr. ROWLAND. Thank you, Mr. Chairman. I have no questions. But I want to tell you how grateful we all are that you did come to share this traumatic personal experience with us. Thank you very much.

Mr. EDGAR. I yield to Mr. Simon.

Mr. SIMON. I have no questions. I simply want to join my colleagues in thanking you, frankly, for your courage in coming here. When you have the courage to come and tell your story, it helps others.

Ms. JOHNSON. Thank you, Mr. Simon, but it isn't courage. It's just resolve. I am committed, I am dedicated to helping. I feel that until some answers are found for this problem, the Vietnam veteran is not home. I want him to come home.

Mr. SIMON. Good for you.

Mr. EDGAR. Lori, I want to thank you also for your testimony and mention just a couple of things.

Congressman Evans has introduced and successfully passed in the House, and we think it will successfully pass out of the Senate, a bill to extend the readjustment storefront counseling centers for Vietnam-era veterans for an additional 3 years. As part of that reauthorization of that storefront program, there are two important features that I think bear on the testimony that you have given. One is the fact that it provides for help for family members. I think you articulately reflect on the fact that it is not just the Vietnam-era veteran who is exposed to post-traumatic stress syndrome and other related psychological problems, but also the

family members of those veterans who have those acute problems also need some counseling and help.

The second provision of the legislation which I think is a major asset to the legislation is a major 2-year study of the Vietnam-era veteran. We have had in the past the Center for Policy Research study and several other studies, trying to understand the special and unique readjustment problems of Vietnam-era veterans. We think it is time to update that information, which is dated 1979-80 vintage, and get an understanding through the vet centers, through the counseling data, as to what the ongoing problems are with Vietnam veterans, and I think that study will help us to determine what long-term help we can give to those veterans who have the kinds of problems that you expressed in your illustration.

I have one question which goes to the point you made about the centers. I have somewhat of a background in pastoral psychiatry. I am a United Methodist minister by vocation and a Congressman by accident. Prior to my incarnation as a Member of Congress, I ran a storefront shelter for women and families called The People's Emergency Center. We had settings in that Philadelphia shelter for discussion of particular problems. You mentioned that once they go through the discussion groups and the rap sessions that they need some additional care.

How would you set up that kind of care? What would be your vision of how it would work? How would you be able to handle the anger that the veterans need to express after their initial contact with the group? Would you have any suggestions as to how we might set up a more long-term investment in that particular veteran?

Ms. JOHNSON. The most immediate need that I saw was the immediate need. When we went into the group, when my husband and I joined, it was necessary to go to Iowa City for any kind of psychological counseling. In the first place, if you went to Iowa City, you either had to check in for 72 hours, or return anywhere from 2 to 3 weeks later. A man in this situation needs immediate help. Whatever is to be done has to be readily available.

The doctor that is contracted in the Quad City area is Dr. Kirk Witherspoon. He has an office in Moline. He is available on referrals. I know of 12 members of the group that he is seeing right now. It is very successful. He is available.

Mr. EDGAR. So you are suggesting in rural and remote areas that, apart from the possibility of going to a traditional veterans psychiatric unit, that the contracting out service be provided to a qualified psychiatrist and make that available to those veterans who come into the groups?

Ms. JOHNSON. Yes, definitely.

Mr. EDGAR. Thank you very much for your testimony. We deeply appreciate your taking the time. Paul called it courage and you resisted that word, but it is risky to come before Members of Congress. We're scary people—

Ms. JOHNSON. Very awesome.

Mr. EDGAR. Even hospital directors sometimes get frightened of us. But we hope that you have discovered that we're human beings and we are interested in the human aspects. One of the reasons I was pleased to ask you to step forward a little sooner than we had

anticipated was that it is easy for us, as Members of Congress, to hear witness after witness who are professional people in the field, who testify quite often before our committees, but as we move out into the field it is more and more important to hear from people who have had first-hand experience. Your first-hand experience was very helpful to the committee.

Ms. JOHNSON. Thank you very much.

Mr. EDGAR. If I could ask the hospital directors and the Regional Director to wait for just a moment, I would also like to move up our second panel this morning, and then we'll put you back on. So if you will just be patient with us, we will get back to the first panel.

I would like to have Dr. James Eckenhoff and Dr. William Sawyer step forward at this time. We would like to hear your testimony, and then we will move back to our regional and hospital directors.

Dr. James Eckenhoff is dean of Northwestern University Medical School in Chicago, and Dr. William Sawyer is dean of the School of Medicine, Wright State University, Dayton, Ohio.

Gentlemen, we are pleased to have you here this morning. I know there are some time pressures involved in your appearance as well. We ask you both to share your statements with us. Your full text of your statement will be made a part of the record. If you wish to summarize, we would appreciate that you do that, and we will then be prepared to ask you some questions.

Thank you for coming.

STATEMENTS OF WILLIAM D. SAWYER, M.D., DEAN, WRIGHT STATE UNIVERSITY SCHOOL OF MEDICINE; AND JAMES E. ECKENHOFF, M.D., DEAN, NORTHWESTERN UNIVERSITY MEDICAL SCHOOL, AND PRESIDENT, MCGAW MEDICAL CENTER OF NORTHWESTERN UNIVERSITY

Dr. SAWYER. Thank you, Chairman Edgar. I am William D. Sawyer, M.D., dean of the Wright State University School of Medicine in Dayton, Ohio. I particularly thank you for accommodating me at this hearing—I'm outside the local district. You have accommodated a terrible schedule conflict that prevented my accepting your invitation to your first hearing.

I appreciate the opportunity to report on the development of the school and of its affiliation with the Dayton Veterans' Administration Medical Center. The Veterans' Administration provided the school substantial support—about \$29 million—through Public Law 92-541 and a 12-month extension of that expenditure authority by Public Law 97-15.

The so-called Teague-Cranston Act authorized support of new State medical schools developed with a major reciprocal relationship with Veterans' Administration hospitals. The ultimate purpose of the law was to provide "the best possible medical care for the Nation's veterans."

My first point is the progress of the School of Medicine. The school was created by an act of the Ohio Legislature in 1973. The school bases its clinical program in community facilities, the Veterans' Administration Medical Center, and the Wright-Patterson Air

Force Medical Center. The school emphasizes the preparation of physicians for careers in primary care. The time table called for both the graduation of the first class and full accreditation in 1980. Progressive expansion to the full enrollment of 100 students per class was projected to be complete in 1982. This time table was kept. Perhaps more importantly, the school's development was achieved without a major disruption within the parent academic institution or among the physicians and hospitals of the community.

Two aspects of the school's mission warrant special comment. These are, first, the preparation of physicians for careers in primary care, and second, the creation of new knowledge.

Of the school's 238 graduates, 68 percent have entered residency training in primary care, that is, in family practice, internal medicine, or pediatrics. The results for family practice are particularly gratifying to us. Of our recent graduates, 30 percent are training in family practice. This is more than double the proportion among the graduates of the other allopathic medical schools in the State of Ohio.

The school's emphasis on preparation for primary care has not, however, prevented graduates who seek training in other specialties from gaining access to programs of their choice. Wherever they have gone, our graduates have been well received. Systematic evaluation indicates that better than 90 percent of our graduates are perceived as being equal to or better than others in their residency training peer groups.

The Wright State University School of Medicine in its short history has become a strong and increasing contributor both of new knowledge and of the application of research and technology to the betterment of the human condition. Dr. Jerrold Petrofsky and his associates have brought new hope to paraplegics and quadraplegics through computer-controlled functional electrical stimulation of muscles.

I would be remiss not to recognize that the spinal cord program at Hines many, many years ago provided some of the initial impetus in the United States to programs of electrical stimulation.

The school's Hipple Laboratory for Cancer Research is examining hormones that govern the production of blood cells in an effort to understand the processes responsible for leukemia and to develop innovative approaches to the management of malignancies. One of the senior investigators has recently demonstrated a new hormone, granulopoietin, that controls the production of certain white blood cells.

The School of Medicine's Cox Heart Institute has pioneered the use of electronic monitoring and computers in the management of patients with acute heart disease. More recently, the Institute has concentrated on the prevention of coronary heart disease and hypertension.

Our program in aerospace medicine attracts students from throughout the world to this country's only civilian aerospace medicine residency. Faculty and graduates are playing a leading role in the medical aspects of our Nation's space effort and in making aviation safer.

Dr. Harvey Siegal leads an innovative education, research and service programs on alcoholism, especially in relation to driving while intoxicated, and other substance abuse in adults and teenagers. His approach emphasizes management on an outpatient basis, an effort that is far less costly than inpatient alcoholism and drug treatment. Evaluation indicates that the results may be superior to those of the more expensive approaches. We are gratified that several States are currently working with Dr. Siegal to initiate similar programs.

I hope that these few examples convey the scope and the progress of our research program and how it is paying off.

My second point is the programmatic integration of the Dayton Veterans' Administration Medical Center and the school, and the positive impact of developments at the center on the care of veterans. The Dayton Center currently has 342 beds for acute care and 148, 284, and 780 beds for intermediate, nursing, and domiciliary care, respectively. In the past decade, the Center's program has advanced importantly in the scope of available medical services. For example, the physician staff has increased by 62 percent and the number who are board certified has more than doubled. Staff physicians are medical school faculty members.

Although the Center's Brown Hospital is not a tertiary level facility, important new services have been added, such as plastic surgery, advanced ophthalmological surgery, expanded hemodialysis, and a whole list of other new and modern procedures. Technology and equipment have been enhanced. Fewer patients now require referral to facilities outside their home area. The average length of stay has declined substantially.

Four of the five medical residency training programs at the Center have been integrated into the graduate medical education programs of the school of medicine. One indication of the change in the residency programs at the Center consequent to this integration is the increase in the proportion of residents who are graduates of American medical schools from zero to 70 percent.

In addition to receiving training, the residents offer both important intellectual ferment of youth and valuable service in their patient care activities. In their service role, the residents are well supervised. During the past 3 years in general surgery, for example, an attending staff surgeon has been scrubbed in from 80 to 85 percent of resident surgeries. In nearly all of the rest, the attending staff surgeon was present physically in the operating room.

The integration of the Medical School and the Veterans' Administration Medical Center is also reflected in the full educational program of the school. One-half of the required clinical clerkship assignments are at the VA Center. These assignments are the most popular among the several choices available to the medical students and are highly sought. This reflects the commitment of the teaching staff and the educational opportunity at the center.

My third point concerns the expectations of continuing support from both the State of Ohio and the Veterans' Administration. Ohio has provided substantial support to the school as facilities, capital equipment, and operating budget, and the State is continuing to meet its commitments. The school will soon occupy a substantial portion of two new buildings, one under construction and

one in the final plan. We currently operate within a budget of approximately \$20 million, exclusive of the costs of residency programs; \$8.2 million is directly from the State. Modest reserves and endowments have been established. Research and development support will significantly exceed \$4 million this year, placing the school ahead of many of the others of similar size and age.

It is important for this joint enterprise that began under Public Law 92-541 that the Veterans' Administration continues the support of the Dayton Veterans' Administration Medical Center as a major, academically affiliated entity in its hospital and health care system. Both fiscal and vigorous administrative support are required. Broad, quality patient care capabilities must be sustained. For facilities of modern standards, further renovation, construction, or both should be implemented. Long-range planning and resource allocation processes within the VA should neither ignore nor diminish the achievements gained by the previous investment of both dollar capital expended through Public Law 92-541 in Ohio, and the human capital of the faculty, staff and students of the school and the Center.

To conclude, we of the Wright State University School of Medicine are proud of our development and achievements, both as an institution and as a partner with the Dayton Veterans' Administration Medical Center. We hope that the Veterans' Administration, this committee, and the Congress share that pride. We intend to keep our commitments and urge the continuation of the Veterans' Administration's commitment through ongoing, quality support of the veterans' care and educational efforts at the Dayton Veterans' Administration Medical Center. Working together, we can contribute further to the well-being of veterans and mankind generally.

Thank you, Mr. Chairman.

[The prepared statement of Dr. Sawyer appears at p. 104.]

Mr. EDGAR. Thank you, Dr. Sawyer. We appreciate your full statement and your statement is well taken.

Let me now call on Dr. Eckenhoff for his comments.

STATEMENT OF DR. JAMES E. ECKENHOFF

Dr. ECKENHOFF. Thank you, Mr. Chairman, members of the committee, ladies and gentlemen. I am dean of the Northwestern University Medical School, and president of the McGaw Medical Center of Northwestern.

My apologies for the tardiness of my written statement. The reason was that I have been in London for the last 2 weeks participating in a symposium on the quality of care in anesthetic practice in England, sponsored by the Royal Society of Medicine. Unfortunately for me, I was cast in the role as chairman of those sessions and as the summator of the symposium. It is not an easy assignment to be put in the position of an American telling English physicians what needs to be done about the quality of health care there. I feel much more comfortable speaking to this group, and I will come back to this point a little bit later.

Northwestern Medical School, as some may know, is a part of Northwestern University, the only private institution among the

Big Ten universities. The school is located in downtown Chicago. We have 182 students in each class, making it one of the largest private medical schools in the country. About half of these come from the State of Illinois, the remainder from throughout the country. There are 22 States and 58 universities represented. Approximately 40 percent of the third- and fourth-year classes at any time will be working at the Lakeside VA Hospital.

In addition to medical students, the school is responsible for programs in nursing, psychology, physical therapy, public health and community medicine, and in graduate work in basic sciences leading to the Ph. D. degree.

Different from many other institutions, our medical school is responsible for graduate medical education of 820 physicians, 750 of whom are residents, and 70 fellows, individuals who have completed their required training but are gaining extra experience in some specialty areas. All specialties of medicine are represented and the selection of house staff is highly competitive, 165 positions available each year for which there are approximately 4,000 applicants.

A description of the McGaw Medical Center of Northwestern University. Northwestern does not own or operate a hospital. It is affiliated with four private hospitals and the Veterans' Administration Lake Shore Hospital, all comprising 2,830 beds, and comprising the medical center. In addition to the VA Hospital, there is Northwestern Memorial Hospital and the Rehabilitation Institute of Chicago, all adjacent to the medical school. The Children's Memorial Hospital is located 15 minutes north and Evanston Hospital 30 minutes away. All have their own boards of directors except Lakeside. The medical center can be looked upon as a loose confederation of hospitals with the university, each supplying members to the center's board of directors, but no decision of the board is binding on any member institution.

Perhaps the principal binding force of the medical center institutions has been the education of medical students and house staff. Most physicians who practice in the center hospitals are university faculty members, and all house staff in the center are members of the integrated house staff program of the center. All students rotate for their clinical training among the center hospitals and, with one exception, all house staff are selected through the office of graduate medical education in the medical school and rotate freely among the various institutions for their training. An important point is that, with the exception of the internal medicine program at Evanston Hospital, no training program is defined as a hospital program but, rather, as a center program. Thus, house staff assigned at any time at Lakeside VA Hospital participate in a training program fully integrated among all hospitals. The particular benefit to Lakeside is a high calibre house staff, all of whom are American medical graduates and all of whom are constantly supervised by faculty of the medical school.

We believe that Lakeside Hospital has one of the highest quality house staff programs in the entire country. Each clinical chairman in the medical school is charged with overseeing the standard of medical care of VA Lakeside Hospital in their respective specialties. The departmental professional staff is selected and approved by the chairman and since, with rare exceptions, all are university

faculty, they must be approved by the medical schools' appointments and promotions committee. A dean's committee meets regularly monthly, and at each meeting one department or section will give a detailed report on its patient activities and educational programs. A member of the Armed Forces organization is present and participates in discussion. The service chief at Lakeside reports to the chairman of the school's department, is a member of the department's executive committee, and with the consensus of the hospital director and the dean coordinates the teaching and research programs of the VA hospital with the chairman. All chairmen and the dean consider Lakeside as one of our principal teaching hospitals and, judging from both student and house staff evaluation, it is one of our best rotations. Most chairmen and many faculty consult at Lakeside on a regular basis. As a dean and former chairman of the department of anesthesia at Northwestern, I regularly spend 1½ to 2 hours weekly working in the operating rooms at Lakeside.

Northwestern is dedicated to the appointment of quality professional staff and graduate trainees, and the goals apply to Lakeside as well. This interest is of sufficient importance that appreciable supplements to VA salaries to attract quality faculty may come from medical school departments, not from university sources, since the university supplies only about 10 percent of my more than \$56 million budget.

In many circumstances, these supplements come from the private practice group income as, for example, through the Practice Foundation. Many fellows and faculty work full time or part time at Lakeside doing research and providing patient care at no cost to the Veterans' Administration. Not only house staff are integrated into the medical center program, but Lakeside professional staff are considered bona fide university faculty and are eligible for university tenure.

The chief of staff is a professor of medicine and an associate dean of the medical school. The chief of staff attends all meetings of the school's council of chairmen and is a member of the university's medical council.

From a dean's perspective, I view the relations between Northwestern's Medical School and Lakeside Hospital as being very close. All chairmen do, too. Further, having worked with six previous hospital directors, the rapport between the present director and my office has never been so close, nor, I believe, has the condition of the hospital or the quality of service delivered to the veteran patients been so good. From a perspective as president of the medical center, I can say that the relationships between the presidents of all the hospitals and common interest in the veterans hospital problems is excellent.

We have done our best to make our medical center run in a cooperative and cost-effective manner and in the best interest of quality care. To that end, we hope that, where possible, medical centers such as ours be given the maximum flexibility so that our Lakeside Hospital is not excluded in any McGaw Medical Center program that is in patient care interests because of rigid governmental rules. Certainly Mr. Moore has done a superior job in working towards this common good.

We also believe that a hospital that is engaged in educational and research programs assures its patients of quality medical care. A hospital staff not exposed to the challenge of teaching young students and physicians and not accustomed to the intellectual challenge of research programs is unlikely to be distinguished or deliver more than average medical care. We believe the best interests of excellence in medical care of the Armed Forces veterans of this country are served by close association with teaching institutions. Specifically referring to our type of private university, where faculty work part time in private practice and part time in research and teaching, we question regulations that would prohibit the Veterans Administration support of research to those who are not full time employed by veterans hospitals. A rigid regulation that prohibits research support to part time professional staff is not in the interest of quality health care to our veteran population. Evidence suggests lack of governmental support for such activities in the United Kingdom institutions is compromising quality health care delivery there.

Thank you for the privilege of presenting this brief overlook of our activities and its relationship to our Lakeside Hospital. I would be pleased to respond to questions and point out that we have made available copies of a brochure which describes in detail the McGaw Medical Center and the part that the veterans hospital plays in that center.

[The prepared statement of Dr. Eckenhoff appears at p. 108.]

Mr. EDGAR. Thank you very much. I want to thank both of you for your statements and your testimony before our subcommittee.

Dr. Eckenhoff, on the last page of your prepared testimony, on page 5, you talk about embarking 2 years ago on establishing the McGaw Center on Aging and its relationship. I wonder if you might go into a little more detail about that, because we are very concerned about the aging veteran population.

At present there are 3.3 million veterans who are age 65, and at that age the incidence of use of veterans facilities increases considerably. We anticipate that in the next 7 years there will be 7.6 million veterans who will reach that age of 65. We have established through the help of our former colleague Margaret Heckler and others on this committee some geriatric research centers around the country. We hope to establish even more.

But we would like to hear just a little word of detail about your center on aging and what it hopes to accomplish.

Dr. ECKENHOFF. It has taken some time for us to get this program in geriatrics off the ground. Part of it is the status quo of physicians. However, we have turned to the framework of the McGaw Medical Center and have established a center on aging. We have recruited a director who reported a year ago. We continue to work in our framework of a practice mode supplemented with teaching and research activities.

The director of the program is also the director of the Presbyterian Home in north Chicago where the average age of the inhabitants is 86. That person also directs the program at Evanston Hospital. We have recently appointed an associate director on the Chicago campus, and the two together will develop our programs. We have made good progress and rapport with the geriatric associ-

ations and facilities within the city. We have had extensive discussions with the chief of medicine at Lakeside, who will be a full partner in this program. It will not be a patient care program, as such. It will, rather, be an educational research program and one that is intended to coordinate the efforts of the patient care programs.

Mr. EDGAR. Thank you very much.

Some of us watched the All Star Game on television last night and watched George Burns get up and sing "Take me out to the ball game." When I see George Burns, and when I see Claude Pepper, a Member of Congress, actively working on behalf of the aging population in our society, I recognize that our whole society is moving to a point where, with increased health care and increased longevity, we have a real commitment we must make, in a positive and upbeat way, to those who are aging in our population. Whether it is a research facility such as the one you're talking about, or a patient care facility within either the VA or in the private sector, we have a lot of work to do in our society to make sure the geriatric needs of our population are well met.

Dr. ECKENHOFF. When I saw Oscar Peterson get an honorary degree at Northwestern 2 weeks ago, I realized how much we had to protect in our geriatric group.

Mr. EDGAR. Dr. Sawyer, Dr. Eckenhoff in his prepared statement I think answered this question, but a few years ago there was a great deal of controversy within the VA about the selection of VA staff positions and how the deans committees play a role in that selection, whether they do or not. I wonder if you could describe your role that you might play in that whole area?

Dr. SAWYER. Presently the appointment of VA staff positions to the joint activities of the school and the VA Center is done through a search process. A committee appointed by the director of the center, the chief of staff organization, coordinated with me and representing both members of the school faculty and the VA staff, they make recommendations to the bed chief at the VA, the department chairmen at the medical school. Those are reviewed and passed to the chief of staff and a recommendation is then made to the dean's committee for action. The dean's committee endorses or rejects. We have never had to reject yet that process.

We have recently completed the recruitment of a new chief of staff for our hospital, and a search was conducted with joint interviews, joint identification of candidates. It so happened that I submitted the name of the ultimately successful candidate, but it was completely coordinated between the director and my staff in joint interviews.

Mr. EDGAR. Thank you.

My final question is just taking advantage of your positions and your knowledge as active members of a medical school faculty. We have had hearings in the last week or so dealing with the issue of chiropractors and their interest in providing care to veterans. It is an issue that we get an awful lot of pressure on. We discovered in our hearings that VA hospitals would have a problem with accreditation if, in fact, those hospitals were to open up to allowing chiropractors on the staff.

How do you think the VA accreditation might be affected if, in fact, service was provided to the veteran by chiropractors? Would there be an impact on their accreditation?

Dr. SAWYER. I would give you a personal opinion. It is my impression that it would have a negative impact, and I would defer to Dr. Eckenhoff.

Dr. ECKENHOFF. I would agree. We have had no problem whatsoever with the osteopathic group. They are fully available and can be appointed to both our resident staffs or to our permanent staff. I would have to see some reason why we should go further with the chiropractors. I am suspicious that it would create difficulties.

Mr. EDGAR. Thank you for your comments.

I yield to my colleague, Mr. Hammerschmidt.

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman.

Dr. Sawyer, Dr. Eckenhoff, we know how busy you are and we very much appreciate your taking the time to come here and give us your valuable testimony.

I remember some 12 or 13 years ago I was a cosponsor of a bill which eventually became Public Law 92-541, that allowed further communication, the joint enterprise between the VA and the medical schools, and you all have used that very well and you both have great rapport with those you are affiliated with, both the VA and the other hospitals, which we commend you for as well.

I think that outside of the people in this room, many of whom are associated with the VA or service organizations, but outside in the general public one of the best kept secrets in the country may be how dependent all of our the citizens are on the Veterans' Administration and its affiliation with your medical schools, because you produce many of the doctors that serve everybody, both specialists and general practitioners. Also, Dr. Sawyer, as you mentioned, the creation of new knowledge is so important. I think the CAT scanner came basically out of the Veterans' Administration and their research and development program, and now you have mentioned the computer-controlled functional electrical stimulation of the muscles to help paraplegics which is now coming out of Wright University. I wish someone would do a big article on that so the general public would know the great contribution that your medical schools make through that affiliation that you have with the Veterans' Administration and what a wonderful marriage and relationship it is.

I don't have any questions but I very much appreciate your being here.

Mr. EDGAR. I would like to yield to my colleague, Paul Simon, for questions.

Mr. SIMON. Thank you. I have no questions. I simply want to commend you and I want to add to Dr. Eckenhoff, along with Oscar Peterson and Cardinal Bernadine, I was one of those to get an honorary doctorate from Northwestern 2 weeks ago—

Dr. ECKENHOFF. I recognized that, but you're not in the geriatric group yet. [Laughter.]

Mr. SIMON. I assume that would entitle me to join the medical school faculty, wouldn't it?

Dr. ECKENHOFF. It probably would.

Mr. HAMMERSCHMIDT. If the gentleman will yield, we can now yield to Dr. Simon and Dr. Sawyer.

Mr. SIMON. In addition to my appreciation for the work you do, and the other, like Loyola here, and Southern Illinois University and the Marion Center, but I think one of the fine things also is to have a member of your profession also in Congress with Dr. Rowland. I think, frankly, Dr. Rowland is a real asset to this subcommittee and to the House of Representatives for the contributions he has been making. I particularly appreciated his interest in this kind of unusual problem we have with veterans who were there for the nuclear tests. He has been digging into that and I personally appreciate it a great deal.

We thank you very, very much.

Mr. EDGAR. Dr. Rowland.

Dr. ROWLAND. Thank you very much for your kind comments, and thank you, Mr. Chairman. I want you to know that the relationship I have had with you since I have been in the Congress has really been great and I appreciate your advice and counsel.

I also appreciate you being here today. I know that time constraints make it difficult for you to go to as many places as you would like to go. I am real pleased to learn of the relationship between the medical schools and Veterans' Administration, and the benefits that accrue to the medical students and residents as well as to the veterans who receive their care from the Veterans' Administration.

I have one question that I wish to ask you, Dr. Sawyer. You mentioned the school's Hipple Laboratory for Cancer Research. We are aware of the ideological effect between radiation and malignancies involving the reticuloendothelial system, and I want to know if there is any research now going on insofar as ionizing radiation is concerned and leukemia or other malignancies of the reticuloendothelial system in the Hipple Laboratory.

Dr. SAWYER. Not specifically, sir. Our research program presently is heavily oriented towards these circulating hormones that regulate or control the production of blood cells and the development of techniques to assay and measure those hormones and their effects.

As those techniques become perfected and the hormones are fully recognized, and their targets are recognized, we will be then engaging in a broad spectrum search and examination of such things as ionizing radiation, chemicals, putative carcinogens, but we are not at that stage presently, unfortunately.

Dr. ROWLAND. Thank you very much.

There is one other question—and either one of you gentlemen might answer this, but perhaps you more so, Dr. Sawyer, since you mentioned that many of the graduates were going into primary care, that some 30 percent were going into family practice.

Do you know—and perhaps I should direct this question to some members of the VA later, and I shall do that—if there are many family physicians being utilized in the VA at this time?

Dr. SAWYER. I can only speak for our institution, and in general it is a relatively small percentage of family practitioners who are utilized. It tends to be more the conventional medical specialties.

Dr. ROWLAND. Thank you very much for being here.

Dr. Eckenhoff.

Dr. ECKENHOFF. I would agree with that statement. Most of our faculty that are involved in family practice are in the suburban area, and the group downtown tend to be more specialized; therefore, we have relatively few family practitioners that work at our VA.

Dr. ROWLAND. Thank you, gentlemen.

Thank you very much, Mr. Chairman.

Mr. EDGAR. Before sending you off, and again thanking you for your testimony, one of the questions that we are trying to find a solution for is to look at the future of VA health care. It is my hope that the medical affiliations with the major medical schools across the country will help us in determining what the future of the health care system should be for veterans.

What kind of creative health care network should we set up? How should we reach veterans who are in rural or remote areas, who can't make access to the 172 veterans hospitals? What kind of operation should we set up to meet the unique needs of the aging veterans who will appear in the demographics over the next 10 years, but then fade down again? How do we put institutions in place to meet that geriatric need without putting institutions in place that may not be needed 20 or 30 years down the line?

How does the veterans health care system stay at the cutting edge of health technology with the \$200 billion deficits this year and next year, the following year, and the following year, and the commitments we have made in the defense area? How do we keep a veterans health care system at the forefront of health care as opposed to allowing it to sink back into deferred maintenance on its facilities, deferred purchases of major equipment. How do we keep it at the cutting edge of health technology? How do we make sure that the research we are doing in the veterans system and in the private sector is fully utilized in the future health care delivery for veterans?

What are some models that might be developed in relationship to community hospitals that could have perhaps ambulatory care clinics next to those community hospitals to share facilities? What kinds of innovative, thoughtful ways can we deliver in an efficient and cost-effective way health care to veterans over the next 10, 15, 20 years?

These questions I don't expect immediate and specific answers to, but they are questions I want to address to our hospital directors, to our regional directors, to the health professionals in Washington, the health professionals in the field, and particularly to the health professionals who are operating the medical schools across the country, because as you know, the veterans health care system is the largest provider of health care from a Government standpoint in the Nation and it is not going to disappear. It is aging in terms of facilities and equipment. How do we keep it as current as possible and how do we make sure that the veterans health care system stands at the cutting edge of health technology?

Dr. ECKENHOFF. If I can make one brief response to that, I don't think the problems are unique to the Veterans' Administration hospitals. I think they face all the institutions of the country, not only in bed patients but in ambulatory patients. This is what I was

referring to when I said that I hoped the veterans hospitals that were affiliated with medical centers such as ours could have the flexibility to work with the overall center institutions in the development of programs that would seek solutions to the problems you put your finger on.

Mr. EDGAR. Thank you.

Dr. SAWYER. Thank you, Mr. Chairman, for not asking us to answer your questions. They are beautifully stated and very much to the point.

I would like to endorse wholeheartedly Dean Eckenhoff's comments about permitting greater flexibility for new ideas and new ways of approaching things within the Veterans' Administration medical centers, affiliated particularly with medical schools. I think we could both regale you for far beyond your tolerance with examples of impudence of innovative programs related to what I shall politely call "administrative inflexibility" in the Veterans' Administration local areas, districts, regions, and the total system. There seems to be many, many instances—and he cited one—the requirements on research support.

For example, Mr. Hammerschmidt kindly complimented us on our program of functional electrical stimulation under computer control, not supported by the Veterans' Administration for, among other reasons, the restriction to people who were not five-eighths or better VA employees from being recipients of VA grants. I could go on, and I am sure Dr. Eckenhoff could, and I don't want to do that. But I think we could plead for a greater flexibility of experimental or innovative approaches.

Mr. HAMMERSCHMIDT. Would the chairman yield?

Mr. EDGAR. I yield to the gentleman.

Mr. HAMMERSCHMIDT. Dr. Sawyer, as you said, are those impediments largely from statutory requirements or are they regional or district policy?

Dr. SAWYER. I would suggest that they probably represent all of those elements. It strikes me that it is possible almost to find a rule, a policy, or a law that says you cannot do anything if someone wants to find such a rule, policy, or law. I tend to prefer the approach that says "let's find a way to do it if it, seems like a good thing to do, but that sometimes seems hard to accomplish."

Mr. HAMMERSCHMIDT. Thank you.

Thank you for yielding, Mr. Chairman.

Dr. ECKENHOFF. There has been a recent proposal, too, that only full-time VA employees, physicians, could get VA research funds. That has not been accepted, to my knowledge, but I think this is one of the things we are alluding to as well.

Mr. EDGAR. I think the observation you make about the part-time employees having access to helping with research is a point well taken and one that we will take back to Washington and review.

Again, thank you for your statements and your comments.

Mr. SIMON. Mr. Chairman, I am not a member of this subcommittee, but I think if you could provide to the subcommittee, each of you, a letter with specifics, the changes that you think are desirable. We are not suggesting that we can snap our fingers and bring about those changes, but I think if you can be as specific as possi-

ble, that would be of help to this subcommittee and to those of us in Congress about where we want to go and what we can do, if I may give you that assignment in addition to everything else.

Dr. ECKENHOFF. We are pleased to accept it.

Mr. SIMON. Good.

Mr. EDGAR. Without objection, we will make those letters a part of the record, if they can be given to us in a timely fashion.¹

Let me now ask the regional director and the hospital directors to return for a brief moment, and then we will move on to our remaining panelists.

I think all of you, as hospital directors, were present and heard my questions—which were long and involved—about the future of health care within the VA. I would like to provide an opportunity for each of the hospital directors to answer two questions:

The first question is: What areas of service in your specific hospitals are you most proud of? What are the two or three most important services that you provide, the most important innovations that you have developed, things that you are most proud of.

The second question for each of you to respond to is: What areas are the most concerns, what are the specific problems that you face within your health care system that you think this committee or the VA central office should, in fact, deal with either this year or over the next couple of years? The first question deals with the areas of promise and pride that you have within your hospital system, and second, what are the areas of problems and concerns and frustrations that you face that you think need to be addressed over the next period of time.

Let's begin with Mr. Carr and we will simply move down the panel.

Mr. CARR. First and foremost, I would say we are extremely proud of our dedicated and highly qualified medical personnel. This is reflected by the high rate of hospital accreditation and the VA's systematic external review program, and also reflected in the high quality of care provided at the Westside VA Medical Center.

I am likewise very proud of the quality of our affiliation, and I would agree with many of the comments that we were just privileged to hear. The quality of the affiliation is reflected in the outstanding character of our professional training program, and we are very proud of that.

We are also very proud of our relationship with the service organizations that represent our veteran patient population in the Chicago area. I think our relationship with those service organizations have enhanced considerably our ability to provide service to the veterans. I think that relationship has been helpful to us in terms of the support we have received from the service organizations throughout our program.

These are the three things we are most proud of.

In terms of three critical needs, the first and foremost would have to be the need for a major construction and renovation programs, which is planned, and which you mentioned earlier is scheduled for final planning funds in 1983 and the beginning of construction in 1984. That involves a new ambulatory care building

¹ Not received at time of publication.

and partial renovation of two structures on the grounds of the medical center.

You have to understand, as a downtown Chicago hospital, occupying land adjacent to the University of Illinois Medical School, that is all we have and there is not going to be any more because that is the entire piece of property that we occupy. We therefore have to maintain and enhance that facility at every opportunity. I am delighted with the support we have gotten from Congress and the administration in terms of providing that major construction and renovation program.

The second critical need I alluded to earlier, the one for additional funding for staffing and equipment. As Mr. Zamberlan stated earlier, our personnel funding has been eroded over the years because of the necessity to divert personnel funding and FTEE to pay for the unfunded cost of all other types of expenditures, the cost of which had exceeded the provisions for inflation in our budgets.

The third and final thing is one that the Veterans' Administration has struggled with significantly over the last couple of years, extending their efforts over the last 8 to 10 years, and that is the provision of computer systems for the medical centers. We are in desperate need of computer systems to allow us to benefit from the advanced state of technology that has been utilized to such a high extent in the private sector. We do desperately need to catch up in that area.

Thank you, sir.

Mr. EDGAR. Thank you.

Mr. Fears

Mr. FEARS. I believe the thing that I am proudest of in this medical center is the quality of care that we deliver in spite of many resource constraints, as was alluded to earlier. This quality of care has maintained a high standard through some very new and innovative technologies, you might say, for the delivery of care. I am not talking about the actual treatment of the patient. I am talking about new ways to deliver care.

The one that comes to mind immediately is our palliative care program that we have here at Hines. It is a program in which we allow a patient who is terminally ill to die in the environment that he wants to die in, which is usually at home. We actually have physicians in this hospital that make house calls. That gives the patient and his family the support that they need during a very trying time of a family's existence. It gives them the support they need to have the patient die at home. This does two things. One, it allows us to give very high quality care, and two, it is very, very cost effective.

The biggest problem that I see that we have is the obtaining of capital resources. This can be broken down into two basic categories, the first being the replacement we need for an aging facility. The building that you are currently in—by the way, I apologize for the noise and the lack of air-conditioning—this building was built in 1922. It is obviously not an ideal place for the delivery of health care. The buildings that we deliver psychiatric care in are really in poorer condition than this one. I think it is very important that those buildings be replaced, but obtaining the capital resources to

replace those buildings is a very difficult and time-consuming process to go through.

The second thing is, I think you all know that medical technology is rapidly expanding, and it is extremely expensive. There are several examples that come to mind, the first being right now we have an aging betatron where we deliver therapeutic radiology for this entire section of the country. That betatron has gone beyond its useful life and I now am in a position of having to obtain \$3 million to replace that particular instrument. It is very difficult to obtain that with the current methodologies of gaining resources.

An example of the problem that VA has had in obtaining resources is the delay we have had in obtaining CAT scanners. I hope that we don't have the same problems in obtaining NMR scanners as that technology is developed. They also are very expensive machines and it is the future of health care. NMR is something the VA should get into very rapidly, and this is going to take a large amount of money and capital expenditure. The capital has to be there in order to furnish this type of technology to our veteran patient.

Mr. EDGAR. Thank you very much.

Mr. McGee.

Mr. MCGEE. I would comment about the wonderful employees and the innovative services that we have that have so enabled the director to administrate and to meet the needs of the veteran. We have been involved in programs allowing the veteran and the patient to be free from dependence upon the hospital. Our special outpatient activities, such as our senior adult Center, a day-long program for older veterans; the day treatment center, a therapeutic program for long institutional psychiatric patients; our community care programs and foster care for veterans all attest to meeting the needs of keeping the veteran out of the hospital.

Also, we have tried to introduce in the last few years the innovative services. We have developed a unique program aimed at the special needs of individuals suffering from post-traumatic stress disorders. While not restricted to the Vietnam veteran, the vast majority of those requiring this special program are young veterans.

Finally, we do not ignore the older veteran. We have developed a geriatric psychiatric program in which we are attempting to put our older, frail psychiatric patients in a group of buildings where they can be specially cared for and not be injured by the young, more aggressive type patients.

I think we have done a great deal with our staff in developing more sharing with the Navy and the great many ideas that come forth and what we can do with that from a Great Lakes base surrounding us. The most recent thing we have tried to innovate in our fairly new affiliation is critical care medicine, in which we feel that our facility should greatly improve the delivery of care to our ill veterans.

I think our major needs are that, particularly at north Chicago, we are overwhelmed by the number of buildings and the great expansion of buildings throughout the years that have gotten extremely costly. I would guess three-fourths of our buildings have been designated as eligible for the historic register. They are diffi-

cult and expensive to maintain. Our youngest buildings are at least 25 years old, most of them 60 years old, and were not designed for their current use.

With the growth of new technologies and the growth of critical care medicine, we definitely need to remodel our intensive care facilities. And with this project that we have coming, with your help, some \$48 million, we will be able to meet some of those needs.

Mr. EDGAR. Mr. Moore.

Mr. MOORE. Thank you, Mr. Chairman.

I think that I would say that not only am I proud of, but our entire medical center is proud of, the quality of care and the quantity of care that we deliver to our veteran patients. I would also say we are proudest of our medical staff and their competence which is manifested in the care and treatment of the patient.

One of the things that I believe is exceptional for Lakeside, as well as any other hospital in the system, is that all of our clinical staff have faculty appointments at the university. Previously that was not true in the ambulatory care area. Also, I am exceedingly proud of the research endeavors of our clinical staff.

Mr. Chairman, if you would allow this levity for our needs, I could answer all three of those questions by saying "money, money, money." However, I would—

Mr. EDGAR. And more money.

Mr. MOORE. And more money. But I would really like to say that if you look at the Veteran's Administration and its clinical staff, it is the purest form of academic medicine. Unless we address some ways of providing continued technology, then we are going to erode the possibility of attracting to the Veterans' Administration the kind and quality of staff that we want and would like to see continue.

Thank you.

Mr. EDGAR. Thank you very much. I appreciate all of you being concise in your response to that question.

If, for the record, you want to amplify on the question I asked earlier of the medical directors, as well as these questions, as to your view of what the future of the veterans health care system should be, we would appreciate that and for the record it will be made a part of that record.¹

Mr. Zamberlan, I have a couple of additional questions, and I would ask that you be brief in response, and if you have additional detail that you want to provide for the record, I would appreciate that.

Is there a problem in recruiting and retaining nurses in this medical region?

Mr. ZAMBERLAN. Mr. Chairman, at the present time we do not consider that a real issue. Three years ago it was an issue. As I expressed in my prepared statement, 3 years ago our turnover rate for RN's was approximately 30 percent. At the present time it is less than 15 percent. We find that acceptable. Most of the targeted positions are filled and we have commitments to fill the remaining vacancies. So, in Chicago, it is not a serious situation. In fact, in

¹ See p. 69.

my entire region I only have a few beds that are closed because of RN shortages.

Mr. EDGAR. I wonder if any of the hospital administrators want to respond to the question of recruitment and retention of nurses, or whether or not there are any specialty areas in the health care fields that you have difficulty in recruitment and retention.

Mr. MOORE. I would respond, because Lakeside had the greatest deficiency in nurses 4½ years ago of the medical centers in this area. When we talk about budgetary constraints, one of the areas that we immediately allude to are the perks in the private sector that allow the nurses to go there versus coming to the Veterans' Administration. In terms of retention, what we have tried to do, in addition to recruitment and retention, was to enlarge the ratio of nurses to patients.

I think one of the things that we sometimes overlook is that the staffing patterns are considerably different in the private sector than they are in the public sector, so we are faced with the nurses being overworked and, like a rubber band, it gets very taut. So they find themselves leaving us.

Mr. EDGAR. In some of our visits to the hospitals in the western Pennsylvania area and in discussions with the nurses, we heard time and again a concern that in the private sector, while the pay is comparable for nurses—and in some instances the veterans pay could be a little higher than some could receive in the private sector—the one benefit that the VA does not provide is the benefit of education and expanded continuing education.

Do you find that a comment that your nurses make to you when you talk to them about their services, or is that not an issue in this region?

Mr. FEARS. Speaking for Hines, 2 years ago that was a definite problem in this region, but through the affiliation with our medical school and the sister nursing school, we have been able to work that problem out locally so that it is no longer a problem.

Mr. EDGAR. Have any of the hospitals used the nurse scholarship program that was established?

Mr. CARR. Yes, we have.

Mr. FEARS. We have not.

Mr. MCGEE. We have.

Mr. EDGAR. OK. Mr. Zamberlan, let me ask you just a couple other questions.

What problems in security do you face in the Chicago area hospitals?

Mr. ZAMBERLAN. I am not specifically aware of severe security problems except for the retention of capable security personnel. It is very similar to what you described as happening in western Pennsylvania with the retention of nurses, and that is, we can recruit but we cannot retain qualified security personnel. We just aren't competitive in salaries and benefits.

Mr. EDGAR. What are the problems in retention of security personnel in this region?

Mr. ZAMBERLAN. Because of the unemployment situation, we are able to recruit them, but once they gain job experience, they are hired by some other security organization. We simply cannot retain

them as GS-5's, especially in Chicago where this is insufficient income to meet their financial needs.

Mr. EDGAR. Let me ask the medical directors whether or not they have specific security related issues that they would like to bring to the attention of the committee.

Mr. FEARS. I absolutely do. The lowest paying job in the surrounding communities of a qualified policeman is \$5,000 to \$6,000 more per year than my policemen, and yet we have the same hiring standards. This gives me a 40 to 50 percent turnover rate, annual turnover rate, in my security force. When you are dealing with an organization as complex as this one, a city literally of 3,000 to 4,000 people, with tremendous amounts of expensive equipment laying around, it is obvious that that sort of turnover is going to cause some major problems.

I have several areas in which the dollar loss has been significant, even though I would say our police force here is very, very good, it is just a matter of keeping good, trained people on board that has caused a significant loss in—

Mr. EDGAR. Have you requested of the central office an upgrading of the staff positions of the security force?

Mr. FEARS. We have made numerous requests of the central office and the Office of Personnel Management to give us some relief so that we can maintain some sort of competitiveness as far as salaries are concerned for our security force. At this point we have received no satisfactory response.

Mr. CARR. If I might add here also, in regards to the impact of the salary level, the observation should be made that it's not just a matter of turnover. Sometimes turnover constitutes relief in terms of low quality people that you would otherwise have to retain. We find that the low salary levels don't allow us to compete for the higher quality people, so we end up with more problems among the staff that we are able to retain. That constitutes a problem of a continuing character.

Mr. EDGAR. Let me ask three quick questions that I would like you to respond to for the record, and we will make this available in letter form to you.

First, Mr. Simon asked that you respond in writing to this question: Public Law 97-72 authorized the VA to provide health services for veterans who could have disabilities associated with exposure to radiation. He asked that you provide for the record how many veterans have been treated by the VA in the area under this provision and what does the VA do in outreach to veterans and give them information about their eligibility for that evaluation.

[Subsequently, the Veterans' Administration furnished the following information:]

Medical District No. 17 ionizing radiation exams—FYTD June 30

	<i>Claimants</i>
VAH Hines.....	2
VAMC Lakeside	8
VAMC North Chicago	1
VAMC West Side	1

Mr. EDGAR. The second question is in the area of agent orange. Here in the Chicago area and throughout the country this is a very

important issue. We, as a committee, would be interested in how many veterans have been treated by the VA who have come with systemic diseases or other related concerns that they believe are associated with exposure to the defoliant agent orange.

[Subsequently, the Veterans' Administration furnished the following information:]

MEDICAL DISTRICT NO. 17 AGENT ORANGE EXAMINATIONS—WORKLOADS FROM 1980 to MAY 1983

	1980	1981	1982	Through May 1983
VAMC Lakeside.....	72	36	44	31
VAMC West Side.....	249	283	71	56
VAMC North Chicago.....	44	58	45	49
VAH Hines.....	158	202	288	230
District totals.....	523	579	448	366

Note: Based upon this data, an increase of 22.5 percent Agent Orange Exams is projected for fiscal year 1983. We have utilized traditional methods of advising veterans of their eligibility for benefits, including a brochure specifically dealing with Public Law 97-72 eligibility which is available at all of our VA facilities including readjustment counseling centers.

Mr. EDGAR. Third, we would be interested to know what unique problems your veterans facilities have as it relates to female veterans, accessibility for female veterans, privacy for female veterans, and whether or not female veterans can be fully cared for under your system.

[Subsequently, the Veterans' Administration furnished the following information:]

Attached please find a copy of a letter to Dr. Susan Mather, the Department of Medicine and Surgery liaison to the Administrator's Committee on Female Veterans, included to provide information regarding the care of female veterans in Region 4.

VETERANS ADMINISTRATION,
GREAT LAKES REGION,
Ann Arbor, Michigan.

Subject: Plans for the health care of female veterans.

Susan H. Mather, M.D. (111),
Program Chief, Cardiopulmonary Diseases, VA Central Office, Washington, D.C.

1. Enclosed are the plans on the care of female veterans prepared in response to DM&S Circular 10-83-14 by the 24 medical centers and 1 independent outpatient clinic in the Great Lakes Region.

2. Mr. James R. Donachie, Medical District Director, Medical District 14, reviewed the plans to assure accessibility to health care for female veterans prepared by the facilities in the Great Lakes Region. Mr. Donachie found that all the plans address the four required areas identified in Circular 10-83-14. These areas are discussed below.

a. All facilities in Region 4 indicated that female veterans received the same complete physical exam as males with the addition of a breast and pelvic exam. In addition, 68% of the facilities indicated that a pap smear was included as part of the examination procedure for a female veteran unless the record clearly indicated one had recently been done.

b. In all cases in Region 4, female veterans are treated in VA medical centers under conditions which provide complete privacy to the patient. Medical centers indicated that female patients are admitted to private rooms with private bathrooms. In cases where female veterans are admitted to semi-private rooms, they have private bathrooms or a shared bathroom with locking adjoining doors.

In the 19 nursing home care units in the Region, female veterans are housed in private rooms or in multiple bedrooms designated for female veteran care. In those cases where female veterans do not have separate bath facilities, special arrangements are made so female veterans can bathe. In addition, in cases where such conditions exist, facilities have noted this and have provided for correction through

future construction projects. In the two VA domiciliaries in the Region, female veterans have private rooms with private toilet and bathing facilities.

c. In all cases when care is rendered in outpatient areas, female patients are seen in private examination rooms that are appropriately equipped. In approximately 50% of the facilities in the Region, a specific gynecologic clinic exists for the care of female veterans.

d. No facility in Region 4 indicated any limitations to service because of privacy considerations. However, stations did outline referral procedures, the criteria for referral, and to whom referrals would be made in cases where a level of care higher than that available in the facility was required. Referral patterns do exist where needed between VA medical centers in a district or between individual VA medical centers and community hospitals.

e. All the facilities in Region 4 noted that care to female veterans for gender related conditions in both inpatient and outpatient areas is rendered by full-time staff physicians with gynecologic expertise or board certified gynecologist. Where board certified gynecologists were not on full-time staff, they are available on a part-time basis or through consultation.

3. At the May 10, 1983, Great Lakes Region hotline call, it was agreed that the Districts and facilities in Region 4 would take additional actions regarding the provision of health care to female veterans. These actions include:

a. Addressing the provision of health care to female veterans in the District MEDIPP planning process.

b. The preparation of a station policy statement for the care of female veterans.

c. The inclusion of care of female veterans in continuing staff education and quality assurance programs at each facility.

d. Providing an estimate of current and future spending to provide care to female veterans.

4. The necessary examples, prototypes, and formats to implement the above recommendations are being prepared for distribution to the facilities in Region 4.

5. In a number of cases, clarification or additional information was requested from a medical center. These additions are attached to the original submission provided by the facility. The facilities in Region 4 were both prompt and cooperative in accomplishing this task. Each of the facilities in the Region provides to female veterans, as they do to all veterans, the highest quality health care possible.

A. ZAMBERLAN,

Regional Director, Great Lakes Region.

Mr. EDGAR. Finally, we would be interested, again, in your responses to the question of the innovative future of the veterans health care system for the record.

I yield now to my colleague from Arkansas, Mr. Hammerschmidt.

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman.

I want to commend you for asking the key question to each of the directors and getting their response, as to what they view the weaknesses and shortfalls are in the system as it pertains to their own institution. We need to do this, of course, in all regions across the country, and we are particularly interested in this region and District 17.

Mr. Moore summed it up, I guess, as we always get it summed up—"money, money, money." For that reason, I think it is important that we know that you have certain goals and certain construction projects that you want to accomplish, certain medical requirements that you want to meet. But we also need to remember that this agency is a \$26 billion agency and it now has the largest health care funding that it has ever had, \$8.1 billion. It also has the largest construction program it has ever had, between \$800 million and \$900 million all of which would have been in the 1984 budget except we are taking care of some of that in the supplemental. But for all practical purposes, we will be spending between \$800 million to \$900 million on construction in the next fiscal year.

I think it is important that we look at the broad picture, even though you have to look at your own institution and your own hospitals as you run them, because there is never enough money to go around. I just hope that these new watermark figures on hospitals and health care and construction protends the future. I hope that now we're going to go up instead of going down, as we have been, and that is the hope of this committee, I am sure.

I have one other question that I think we ought to get on the record, or maybe you could just answer it briefly, Mr. Zamberlan. That is, what is your situation with respect to compensation and pension examinations? Are you current on that? And if you aren't prepared to answer that now, you could answer it later for the record.

Mr. ZAMBERLAN. No, Mr. Congressman, we are current. We track that very closely, as we do agent orange exams.

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman. That's all I have.

Mr. EDGAR. Dr. Rowland.

Dr. ROWLAND. Thank you, Mr. Chairman.

In your testimony, Mr. Zamberlan, you indicated that there was some significant initiatives now taking place with reference to agent orange research. We have heard this week that Dow Chemical may feel there is something more than just chloracne skin disease associated with dioxin.

Can you tell me what some of these initiatives are?

Mr. ZAMBERLAN. Mr. Congressman, I was referring to the twin study with regard to agent orange. This is where we have a twin who served in Vietnam and one who did not, and we will be tracking them. It is a cooperative study, and our St. Louis Medical Center is the principal hospital. Hines is also involved with this study.

Dr. ROWLAND. I see. Thank you.

Mr. EDGAR. When do you expect the twin study to be complete?

Mr. ZAMBERLAN. It is expected that all exams will be completed by August 1985, and preliminary results are expected by February 1986.

Mr. EDGAR. Thank you.

Dr. ROWLAND. Mr. Chairman, I have one other question—and Congressman Simon referred to this. With reference to treating veterans with service-connected and non-service-connected disabilities, what is your policy about that and how well is that policy accepted by the veterans who receive treatment?

Mr. ZAMBERLAN. It is our intention to treat all eligible veterans. We do give preferential treatment to service-connected veterans for service-connected conditions.

Dr. ROWLAND. A person who comes in, a veteran who has an illness that is not service connected, how do you go about determining whether or not to treat him over a veteran who has a service-connected disability?

Mr. ZAMBERLAN. I think the urgency of the patient's medical condition would dictate our decision. If it is not medically urgent, the service-connected condition always receives priority treatment.

Dr. ROWLAND. Do you get many complaints from veterans about the inability to get treatment because of that policy, say veterans who have non-service-connected problems?

Mr. ZAMBERLAN. From a regional standpoint, I have not. Specifically, I think the directors are in a better position to reply.

Dr. ROWLAND. Perhaps some of the administrators can answer that.

Mr. FEARS. I don't believe that we receive any complaints concerning first-time treatment to the non-service-connected veteran. The most complaints I receive is that the law only allows us to followup the nonservice-connected veteran's condition for a limited period of time. The complaints that I get are when we terminate treatment to non-service-connected veterans and tell them their period of treatment is up and now they're going to have to seek treatment elsewhere. We, of course, do not do that to the service-connected, so we get no complaints from them. But the non-service-connected, the time limits do seem to generate quite a bit of unrest and complaint.

Dr. ROWLAND. Does anyone else have any comments with reference to that, or is it essentially the same answer from all of you?

Mr. CARR. I would concur with his answer completely.

Dr. ROWLAND. Thank you, Mr. Chairman.

Mr. EDGAR. Thank you very much, and I want to thank all of you for your patience in coming twice to the witness table.

We would now like to hear from Mr. Michael Jackson, who is the regional manager of region IV's readjustment counseling program of the Department of Medicine and Surgery of the Veterans' Administration. Mr. Jackson, if you have others who are going to join you at the table, we would invite you to introduce them before you give your testimony.

STATEMENT OF MICHAEL JACKSON, REGIONAL MANAGER, REGION IV READJUSTMENT COUNSELING PROGRAM, DEPARTMENT OF MEDICINE AND SURGERY, VETERANS' ADMINISTRATION, ACCOMPANIED BY DR. RICHARD SHEPHERD, ASSISTANT REGIONAL MANAGER FOR COUNSELING SERVICES; EARL BROWN, ASSISTANT REGIONAL MANAGER FOR ADMINISTRATION; DR. LEONARD PORTER, TEAM LEADER, CHICAGO HEIGHTS VET CENTER; JULIANNE VIDUYA, CLIENT, VET CENTER, CHICAGO HEIGHTS; DAVID BINGAMAN, TEAM LEADER, OAK PARK VET CENTER; AND JIMMY ROSS, TEAM LEADER, CHICAGO VET CENTER

Mr. JACKSON. Thank you, Mr. Chairman.

With me today, Mr. Chairman, are my two assistant regional managers, Dr. Richard Shepherd, to my immediate right, the assistant regional manager for counseling services, and Mr. Earl Brown, who is to my left, obviously not immediately to my left. He is the assistant regional manager for administration. Also the team leader from the Chicago Heights Vet Center, Dr. Leonard Porter, on the right, and to my immediate left is Miss Julianne Viduya, who is a female Vietnam veteran.

Also here are the two team leaders of the other vet centers in the area, Mr. David Bingaman, the team leader of the Oak Park

Vet Center, and Mr. Jimmy Ross, team leader, Chicago Vet Center, sitting immediately behind us.

Mr. EDGAR. Thank you very much. Welcome to the committee. We appreciate all of your patience and attentiveness during our hearings.

Mr. Jackson, your full statement will be made a part of the record and we invite you to read part of it or all of it, depending on your preference. We would hope that at the conclusion of your statement we would be prepared to ask you questions.

Mr. JACKSON. Thank you, Mr. Chairman. My statement is brief and, therefore, I would like to read it in its entirety.

Mr. Chairman, I am pleased to be here today to discuss the provision of readjustment counseling to Vietnam-era veterans in region IV. The States of Illinois, Indiana, Michigan, Missouri, Ohio and Wisconsin comprise region IV. There are 18 vet centers within the region.

In January 1982, 14 vet centers were fully operational; all 18 vet centers became fully operational as of January 1983 with a total of 79 staff, 73 percent either Vietnam or Vietnam-era veterans. These centers are supported logistically by 14 VA medical centers and one VA outpatient clinic. While programmatic responsibility for these 18 sites rests with the regional managers and the assistant regional managers for administration and counseling, a full range of readjustment counseling services are provided within these centers.

The total number of Vietnam veterans served to date in region IV is 43,388. Of this total, approximately 75 percent have been combat veterans, and the remaining 25 percent Vietnam-era veterans. Early on in the program it appeared that the region was having only limited success involving blacks, native Americans, Hispanics, and females in the vet centers. However, the number of black veterans now seen represents approximately 28 percent of the total number, with Hispanics representing approximately 3 percent and native Americans approximately 1 percent. Female veterans represent approximately 2 percent.

Our workload data indicate that we have had approximately 111,489 visits to our vet centers for service since the first vet center in this region opened in Chicago in January 1980. The number of Vietnam veteran family members seen to date in this region is 24,684. At this time, there are 56 contract/fee providers within this region providing readjustment counseling services to veterans and their families. There are an estimated 1,412,860 Vietnam veterans residing within this region, the majority of whom are located within urban centers or metropolitan areas.

Within region IV eight new team leaders have been recruited since January 1982 to either replace those who had resigned or had been promoted or to lead a new team. Twenty-one additional team members have been hired since that date as replacements for staff who had left or as members of new teams.

The current state of affairs in this region finds the regional manager's office staffed with two assistants—one for administration and another for counseling services—and two secretaries. All regional managers' offices have been equipped with word processors. Obviously, these additions have improved accomplishment of the

tasks at hand. However, there usually seems to be more tasks than time and people to accomplish them. The additional personnel and the benefits of a word processor have assisted in diminishing the management-by-crisis method of operation.

The VA central office program director has been successful in augmenting the VACO staff with three assistant directors and additional clerical staff. Since January 1982 the distribution of Program Circular—June 1982—Program Guide and Program Policy Guides 1 and 2 have been welcome initial efforts toward systematizing our program operations. In January of this year, revised guidelines and new operating instructions for the contract/fee program were issued. These changes helped to streamline referral procedures and outline areas of responsibility of VA organizational elements.

In fiscal year 1982, team leaders were instructed to develop detailed budget plans for the vet centers in corroboration with VA fiscal offices. These efforts have also been helpful for planning purposes. VA medical center personnel have learned more about outreach centers and outreach staff have, through experience and training, gained a better grasp of VA regulations and established operational procedures. In order for this learning process to continue, all team leaders in the region were instructed to have supervisors training given by VA central office personnel service.

Excellent regional-wide training conferences and several district-level conferences have been held within the past 12 months. Most of these have been supported by the mid-Atlantic Regional Medical Education Center [RMEC] with a combination of VA and non-VA faculty. These training experiences have helped in the continuous orientation of outreach staff to the VA system and procedures. Of equal significance, these experiences have allowed traditional VA staff to gain more of an appreciation for the people of Operation Outreach and what we do. The training for regional managers remains quite limited, although options are being explored on the national level to improve this situation.

The national coverage of the "Salute to Vietnam Veterans" in Washington, D.C. in November 1982 has helped improve the morale of all Vietnam-era veterans, including the vet center staffs. The commendations and cash awards given to outreach staff from across the country who provided emergency readjustment counseling to veterans and their families during that week meant a great deal to our staffs. Special acknowledgements and awards for outreach staff have been initiated by certain medical center directors for special contributions and crisis interventions that have defused dangerous situations. The issuance of special contribution and performance awards by my office has been an attempt to begin to deal with the matter of the long-neglected recognition of Vietnam-era veterans.

The sense of isolation, the stressful nature of outreach work, the frustration and uncertainties mentioned earlier, and the fact that many of the outreach staff are Vietnam combat veterans themselves, prepares the stage for our staff to experience emotional burnout. Our program needs a mechanism for taking care of its own, an employee assistance program staffed by clinicians sensitive to the work and related problems and professionals whom staff

would willingly see with no fears of their confidentiality being violated. In order to continue "to care for him who shall have borne the battle and for his widow and his orphan" in the Vietnam war, continued fiscal autonomy and integrity is essential.

During the past 16 months the personnel within this region have met the challenges of program transition and growing sophistication. Their adjustments to these changes has not been without pain; we have lost some comrades along the way. For most of the 70 employees in this region, their participation within this program has been a mission, a crusade, if you will, rather than a job. Mr. Chairman, on behalf of them, I wish once again to express my appreciation for being invited to appear before this committee.

This concludes my statement. I, along with the other members here at the table, will be pleased to answer any questions that you or other members of the committee may have. Thank you.

[The prepared statement of Mr. Jackson appears on p. 114.]

Mr. EDGAR. Thank you very much for your statement. I do have several questions and I am sure my colleagues do as well. I would just like to commend you and your staff and colleagues for the great work that you do with the readjustment counseling centers.

I wonder if we could go first to Miss Viduya. As you know this subcommittee, through the full Veterans' Affairs Committee and through the full House, passed a piece of legislation that set up within the Office of the Administrator a Women's Advisory Board. It is our hope that that will become law. In fact Administrator Walters has done a good job in establishing that committee even before the actual law has gone into effect. We also held extensive hearings in Washington relating to the unique problems of women and female veterans.

I wonder if you might take a moment, given your experience, to just make a comment or two about the need to be sensitive within the readjustment counseling service and within the VA of that concern.

Ms. VIDUYA. Mr. Chairman, being a Vietnam veteran, and also being an outpatient at Lakeside Medical Center, and an employee there—I was an outpatient there 9 years ago on an orthopaedic floor. Dealing with female patients at any veterans hospital, they are really not equipped. The women have to have a private room. They put the women near the nurses station so the male patients will not get to them. Gynecological-wise, they do not have the facilities for us. They have to send females out to the medical centers.

Speaking as a Vietnam veteran and dealing with Lakeside Hospital primarily, I am on the agent orange program. They have a fantastic agent orange program there. The poststress, I am going through Northwestern, being contracted out of Lakeside. I am involved with the vet center through Dr. Porter's efforts. I am trying to adjust back to civilian life after leaving there after 12 years.

It is rather difficult for me to explain everything. Being a female Vietnam veteran, being a spouse and an exspouse of a Vietnam veteran, I know what Miss Johnson went through and I know what I'm going through dealing with my child, dealing with my ex-husband, dealing with other Vietnam vets and other veterans. It is difficult for them to understand and when they look at a female they say "Well, you don't understand." We do. There are a lot of female

Vietnam vets out there that are not coming out and admitting they were there. I can understand the rationale and they do not want to admit that.

I am here hopefully to try and get some of them to come and talk, to talk to the men, the counselors, the people at the vet centers. Hopefully they can adjust as I am trying to.

The veterans hospitals are trying to get better with female patients, but they don't have female veterans coming in that often. There may be a few. We have maybe 6 to 15 that I know of, that I personally know that have come to Lakeside. Otherwise, primarily the veterans hospitals are for male patients only.

Mr. EDGAR. Thank you. You have been very articulate in expressing your concern and we are really pleased that you are with us today.

Mr. Brown, I wonder if you might talk for just a minute about your concerns—and maybe Mr. Jackson, Dr. Porter and Dr. Shepherd might be interested in responding as well—to the unique problems of minority veterans who are facing readjustment problems. I wonder if you might say a word or two about that for the committee.

Mr. BROWN. Thank you, Mr. Chairman. I am pleased to be here before you, but it looks like my ears are stopped up and I don't know if that is because of an anxieties of appearing before such distinguished people as you.

Mr. EDGAR. It's a high panel, but it's not that high. [Laughter.]

Mr. BROWN. We are certainly aware of you and your committee's support in terms of our program. We appreciate that.

I have been with this program since day one. Prior to that I had been a supervisor here at Hines for the drug abuse program. When I was selected for a team leader's position at the first vet center that opened in Chicago, and I went for training, I was there for 2 days and I started to call Mr. Fears, telling him I wanted to come back to the drug program because I was not aware of all the significant problems that the Vietnam-era veterans were having.

I think in saying that I kind of got sidetracked in terms of your asking me what were the needs that I see for minority vets.

First of all, blacks don't think that they have mental problems, or very few. You can talk to them, and if you talk to them about going to therapy, participating in groups and stuff like that, just historically they have learned to suppress a whole lot of emotional kinds of things that has been going on with them. They will come in if they have legal problems or if they have financial problems and stuff like that.

Mr. EDGAR. Do they find it a little easier to come to a storefront center versus the antiseptically clean conditions of a traditional hospital setting?

Mr. BROWN. It would depend on the rapport that the individual was able to get with them, how much trust was going on with them and stuff like that. Blacks have this macho thing. There is not a lot of things that they're going to talk about. If they are having bad relationships with their family, their wives, they are going to hold back on that because they think if they share that they are giving up some of their manhood.

We get them in on individual counseling, as long as they've got some problems. If they think they can resolve them, they will leave the program and sometimes we will do follow up and get them back. That is why, in terms of Michael's report here, he had a very small percentage of blacks coming into the vet centers. However, that is growing to bigger numbers at this point.

If they need medication, they will come to the outpatient mental hygiene clinics and stuff. But coming into the vet centers, they are not going to sit down in front of a group of people and talk about their problems.

Mr. EDGAR. Mr. Jackson.

Mr. JACKSON. If I could, I would like to respond generally to that question.

As you are aware, I am sure, I am not involved in the direct delivery of services at each vet center from day to day, so this is a personal opinion that I am about to provide for you.

Blacks generally, I think, historically, have had problems with professional mental health counseling as it relates to having labels put on one and those labels following you throughout your career, such as the EMH programs in public school systems and being placed in different tracks.

But generally, blacks, as well as Hispanics and other minorities, and Vietnam veterans overall coming into our center, primarily a big portion of their problems now is unemployment, needing jobs. As a black, it is my opinion that traditionally, in providing therapy or counseling for minorities, you have to start with the concrete and work toward the theoretical. To the extent that outreach specialists, technicians in vet centers are aware of that and are aware of cultural differences, and can address those concrete issues, the long-term success possibilities are improved.

Within this local area I have been concerned about the limited number of native American veterans using our centers, because I suspect Chicago probably has one of the highest populations of native Americans within the midwestern region. I also suspect that part of that problem is the fact that they tend to want to be a part of their own culture and there are very few—and I don't think there are any native American counselors within the vet centers locally, and there possibly are some similarities to that in relationship to Hispanics. Maybe Dr. Porter and Dr. Shepherd will want to comment on that further.

Dr. PORTER. I would just like to say that it is my pleasure to be here today. I got involved myself in Operation Outreach a little over a year ago and I had the opportunity immediately to be involved in training—it's called phase I training. I learned of the many problems that the vet centers throughout the country had experienced involving minorities or black veterans in their program. So when we were able to open up our center this past January, we put forth a special effort to involve black vets in our program.

Some of the things we do, that we learned is really important in order to get them involved, much of the service has to be delivered in the community, in their home. We do a lot of outreach, and outreach may mean actually going into the home of the veteran, sitting down and talking with him and his family and offering the

services there, apprising them of all the services that are available to them and their family.

As a rule, many of the black veterans are not coming into the centers seeking services. It is true that anybody who served in the Vietnam theater or Vietnam-era veteran can have readjustment problems. Nobody is exempted from it, black, white, or whatever. The same kinds of readjustment problems are prevalent among black veterans. Oftentimes the black veteran finds other ways to resolve some of the problems. We find many of the problems are unemployment, as has been stated, and other personal problems that are not basically going to be discussed initially in a vet center or before a counselor. It takes a while. We try to recognize the culture differences when we do involve black veterans in our program.

But constant outreach is absolutely necessary, and it requires leaving the storefront or wherever you might be located. I don't think your actual location makes a difference. It is just going out to seek the help is something that traditionally black veterans or blacks, period, have not done because of the stigma of mental health that has been traditionally put upon the black population who have been seeking help. It is clear in many of the veterans we talk with who said, "If I seek help it affects my job. It means my employer knows I am getting psychiatric help." It might cause them to be fired. So they find another way to get it done, and many times it is through the local community.

We have, as I have said, and I repeat, through constant outreach, involved black veterans in the program.

Mr. EDGAR. Thank you very much.

I yield to my colleague from Arkansas.

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman.

Mr. Jackson, I noted from your testimony that you have 54 contracts for counseling services, in addition to your storefront vet centers. I wonder if you could compare the quality of service between the actual centers and those contract arrangements.

Mr. JACKSON. Yes, Mr. Hammerschmidt, we will attempt to.

It will be difficult for me to assess the quality of the fees/contract programs, as I am not directly involved with any of the agencies or the private offices of the private practitioners that are providing it.

Our national figures suggest that a veteran to come in to be served in a vet center, it would cost approximately \$20 per visit, as compared to \$60 per visit in visiting a fee/contract program. In addition to that, I am also of the opinion that within the vet centers there is more use of group therapy, rap group therapy, as mentioned by Mrs. Johnson earlier when she was describing her experiences relative to one of her ex-husbands.

In addition to those two points, I am of the opinion that Operation Outreach has gained valuable experiences in terms of servicing Vietnam veterans and their family members, 1-to-1 in counseling, since 1980, and that those experiences learned, as well as the expertise that each staff member brings to the job, I suspect would enhance the kind of outcome or results that we receive at vet centers when compared to an individual visiting a private practitioner or community mental health counselor.

Mr. HAMMERSCHMIDT. In the readjustment counseling program, at what level is an ultimate evaluation done on the success of the

therapy or readjustment counseling? Is that a responsibility at your level, within your region, or does the VA come in from the outside and make that evaluation? Has that ever been done?

Mr. JACKSON. In terms of the quality of the outcome or the effects, I am of the opinion there is no solid evidence to date and that is a weakness or an area that needs to be addressed more and is being looked into at the national level. However, there are quantity productivity standards that each vet center has to abide by as it relates to new veterans per month, as well as number of visits and number of followups.

Now, within each center generally the team leader is responsible, and in most cases the team leader is a person with a professional mental health degree. He is responsible for in-service training and ongoing case consultations at the local level, supported in most cases by the professional mental health disciplines at the VA medical center that supports that vet center, such as the chief of psychology, chief of psychiatry, or chief social worker.

With the addition of the assistant regional manager for counseling services—which in all cases these individuals are psychologists, clinical social workers or psychiatrists—we hope to look at that area more in depth in the immediate future.

Mr. HAMMERSCHMIDT. As you know, the program isn't all that old and it is probably just now getting to the point where you could maybe put some yardstick on its effectiveness.

The Congress is very interested in this. As you know, the Congress has passed this extension bill for 3 years. I don't think the Senate has acted yet, but evidently we are going to extend it for some period of time. All the reports that we get informally are that good work is being done. But the Congress is going to want to know more exactly what the performance of the agency is. It is obvious that we would want to know that. So that is the reason for the inquiry.

Thank you very much, all of you, for your fine testimony.

Dr. SHEPHERD. Sir, if I could make a statement?

Mr. HAMMERSCHMIDT. Please do, Dr. Shepherd.

Dr. SHEPHERD. I, too, am pleased to be allowed to address this committee.

I think it is extremely important to remember that we are, by definition, by name, an outreach program. We are also a treatment program and we do provide direct services, many ancillary services, and to a large extent act as the go-between for the veteran and the established services within the Veterans' Administration.

To measure the success of our program is primarily to measure the success of our outreach, how many people are we reaching, not so much at this point who has been successfully treated but who has been successfully reached. A strong effort is made to comprise teams made up of various ethnic backgrounds and experience and training backgrounds. A recent survey showed that across the board nationally in our program staff members work an average of 52 hours a week. That's 25 percent donated time from each one of these staff members. Granted, there are people working considerably more, and I am sure considerably less, than that amount.

The point is, as Mr. Jackson said, the people in the program feel this is a mission. We work too many hours; we probably are our

own worst enemies; to a large extent we feel, as they said in the Pogo cartoon, "we have met the enemy, and he is us." These are our brothers and our sisters that we are treating, and we feel very strongly that it is a mission. None of us would be any happier than to work ourselves out of this job and have the job done and relinquish back to the Veterans' Administration the entire care package, not just as a back up for us and a cutting edge to find the people who for whatever reasons are not using the program.

Mr. HAMMERSCHMIDT. Thank you very much, Dr. Shepherd.

Not to take anything away at all from the sense of mission that you have all mentioned here, I think it was probably the desire of Congress to do more than just make contact and to make outreach, that the ultimate results should eventually be there. That is the point that I am making.

Mr. Brown.

Mr. BROWN. I just wanted to share something with you. A couple of years ago we had a black Vietnam veteran who had been discharged with a recommendation to his family that he would not be the same as he was when he left home, and that he should go down to the regional office and apply for service-connected disability. He would not do that. A year ago he started going off again. He had a Doberman pinscher dog in his house that barked at him. He took the dog, put it up on the table, and slashed it up in front of his wife and children. It scared them to death. They left.

We picked him up again and tried to get him to go down to the regional office and apply for benefits, but when you talk about psychological, emotional kinds of problems like that, they don't want to get involved. We have a lot of cases like that.

Mr. HAMMERSCHMIDT. Yes, Mr. Brown, I think those type cases will come out very positive in the evaluation that is done. I think it is important that those be reported in some kind of form later on.

Thank you.

Mr. BROWN. Thank you.

Mr. EDGAR. Dr. Rowland.

Dr. ROWLAND. I have no questions, Mr. Chairman.

Mr. EDGAR. I would like to just ask one final question of Mr. Jackson.

If the resources were made available to you to open new centers operated by the Veterans' Administration, would you find in your personal opinion that readjustment counseling provided by a vet center would be more cost effective and of higher quality than that provided by contracted-out services?

Mr. JACKSON. If the resources were available, Mr. Chairman, in my own personal and professional opinion, absolutely.

Mr. EDGAR. Could you identify areas in this region where the veterans population and the need for readjustment counseling could justify the establishment of new veterans outreach centers?

Mr. JACKSON. Yes, Mr. Chairman. Generally, I would think the northern Indiana area, which is currently covered by the Chicago Heights Vet Center; the East St. Louis, Ill., area, which is currently covered by the St. Louis Vet Center that is responsible for not only St. Louis proper but counties within Columbia, Mo. and another city within Missouri, the name of which escapes me at the present time. As well as in southern Illinois or central Illinois, the Illini

Vet Center is the only vet center that exists. So it would seem to me that additional resources in the central Illinois area such as Springfield, Moline, the Quad City area, would probably be appropriate. But again, more in-depth kinds of research needs to be done to verify my opinion at this point.

I also would like to take the liberty to indicate that it is my opinion that vet centers, rather than being staffed normally by four team members, need to have five. Currently the four-member configuration consists of a team leader who spends approximately 60 percent of his time on administrative kinds of issues, the balance of which would be spent in provide direct services, an office manager or secretary who does no direct services, and then two counselors who spend approximately 70 percent of their time on direct services. In my opinion, this augmentation and expansion would be very cost effective for our program of services to veterans and their families.

Mr. EDGAR. Thank you for those comments.

Mr. Jackson, I want to commend you personally for the work that you have done, particularly the ability you had in establishing the centers in this particular area. We get great compliments about the administration of the vet centers in this area and I want to personally thank you for your efforts in that area.

Also, I would like to say to each of you that we appreciate your work and hope that you will respond to Mr. Hammerschmidt's comment about the evaluation process, because this is a critical time. As you know, Lane Evans has introduced the legislation and has gotten it past the House to extend for three additional years the readjustment counseling centers. It is our hope that this will at least say to the staffs you're not going to have a "yo-yo" vocation, that, in fact, there will be some stability to the system. We also have included in that legislation a major 2-year study of the post-traumatic stress syndrome and all of the issues relating to service in Vietnam and its impact on readjustment. We are hoping that that study will give us some data as to not only the future of vet centers but also the future of the health care needs for the Vietnam-era veteran. We will need your assistance in getting a thorough study of the Vietnam-era veteran.

So thank you again for your testimony and your statement. We appreciate your presence here.

Mr. JACKSON. Thank you, Mr. Chairman.

Mr. EDGAR. I would now like to ask for Mr. Harold Blechman and Mr. John Horan, Mr. Patrick De Mauro, and Mr. Thomas Duncan to come forward to the table at this time. These persons represent the Disabled American Veterans, the VFW, and the Paralyzed Veterans of America.

Gentlemen, thank you for being patient with us this morning. Our hearings are going a little longer than we had anticipated, but many of the questions were important to ask. If we don't come up with a lot of questions for you, it is only because those questions have been covered by other witnesses.

We also hope you will take the liberty in responding to any of the questions that we have asked of previous witnesses, if you have specialized comments or concerns of a specific veterans' facility in the area.

All of your statements will be made a part of the record, and we will hear first from the Disabled American Veterans. We invite you to begin your testimony.

STATEMENTS OF HAROLD BLECHMAN, DEPARTMENT ADJUTANT, DISABLED AMERICAN VETERANS, DEPARTMENT OF ILLINOIS; PATRICK DE MAURO, STATE SERVICE OFFICER, VETERANS OF FOREIGN WARS OF THE UNITED STATES, DEPARTMENT OF ILLINOIS; THOMAS A. DUNCAN, JR., PRESIDENT, CHAPTER DIRECTOR, VAUGHAN CHAPTER OF THE PARALYZED VETERANS OF AMERICA, ACCOMPANIED BY HOLLIS HAWKINS, VICE PRESIDENT, SHIRLEY ROHWEDDER, SECRETARY AND RESEARCH DIRECTOR, AND GEORGE DEMPSEY, DIRECTOR, VAUGHAN CHAPTER, PVA; JOHN F. CRYAN, DIRECTOR, VETERANS AFFAIRS AND REHABILITATION, THE AMERICAN LEGION, DEPARTMENT OF ILLINOIS; AND HARLAN KEPPEL, PAST COMMANDER, DEPARTMENT OF ILLINOIS, AMVETS

Mr. BLECHMAN. Mr. Chairman and members of the committee, on behalf of the 780,000 members of the Disabled American Veterans, I wish to thank you for the invitation to participate before your Subcommittee on Hospitals and Health Care.

It is our desire and concern for the veterans of the State of Illinois, northwest Indiana, and southern Wisconsin to review problem areas on hospital and health care in the Chicago metropolitan and surrounding areas. We know America is aging and the life span of most people in our society is increasing while our national birth rate has declined. There are nearly 25 million Americans who are now 65 years of age or older. We can expect to live into our eighties and by the year 2000 the population of the United States will about triple. We haven't done any long-range planning to prepare for the impending tidal wave of change in our population.

Mr. Chairman, in the State of Illinois we have a total veterans population of 1,348,000. This does not include the veterans from northwest Indiana and southern Wisconsin that require the use of VA facilities in Illinois because of the close proximity to their homes. In Illinois, we have 17,000 World War I veterans, 529,000 World War II veterans, 268,000 Korean conflict veterans, and 388,000 Vietnam veterans. The average age of these veterans are, for World War I, 87; World War II, 62; Korean conflict, 52; and Vietnam veterans is close to 40. Illinois has six VA medical centers for a total operating bed capacity of only 4,341.

The VA in Illinois will have a total of 490 beds in their nursing home care unit upon completion of the 60-bed unit which is under construction at the Marion VAMC. Westside and Lakeside VA Medical Centers, which are located in Chicago, do not provide nursing care services. We can predict with reasonable certainty that more beds are needed for the veterans that require this type of care.

We entertain your consideration that Lakeside and Westside VA Medical Centers be funded to provide nursing care services because they are located close to public transportation which provides access to the family members of the veteran. We don't believe we have sufficient hospital beds in Illinois in which to provide for the

veteran. The joint utilization by the VA and the military hospitals in this area are not practical because of the influx of CHAMPUS dependents who are now, according to law, required to use a military hospital if they reside within a 60-mile radius. It used to be a 40-mile radius. As of January of this year, the VA operating bed level was 79,943, with an average daily census of 64,730. This gives the VA hospitals an occupancy rate of 81 percent, which is above the optimal rate cited by the President's private sector survey on cost control.

The fiscal year 1984 budget request also assumes no increases in the amount of health care the VA will deliver to veterans during the coming years. It projects relatively little change from 1 year to the next in the number of outpatient visits, episodes of hospitalization, et cetera. This is completely out of whack.

The VA faces a mushrooming demand for medical treatment due to the aging of World War II and Korean war veterans. These veterans are at or approaching the age when the need for medical care increases rapidly. In addition, the average age of Vietnam-era veterans is now pushing 40, meaning that care needs among these veterans are already beginning to climb.

Everyone in veterans' affairs is aware of these facts, and the VA officials have been nervously talking about the coming "crunch" in their medical system for several years. But, if we are going to avoid crisis when the crunch hits, the time to start preparing for accelerated demand is right now. In fact, much more should have been done up to this point. The VA medical system needs expansion, not contraction.

For the past several years increases in VA medical funding have not kept pace with inflation in the health care economy, which has consistently surpassed inflation in the general economy. During the past year costs throughout the health care economy climbed a whopping 11 percent, even though inflation in the American economy as a whole slowed significantly.

The 5 percent increase the White House budget request recommends in VA medical funding doesn't come close to the 11 percent cost increases experienced in the overall health care economy. Though the VA medical system is more efficient than the private and not-for-profit health care systems, the strain of this yearly underfunding has been showing in the VA system for some time.

We are also concerned by the way the fiscal year 1984 budget request treats prosthetics and rehabilitation research which is aimed at the needs of service-connected disabled veterans. For several years this type of research has taken a back seat to general biomedical and basic science research in the VA medical system's research budget.

It happened again in the fiscal year 1984 budget request. We don't blame the White House for this. The priorities on the VA medical system's research programs are established within the VA. We, therefore, blame the VA for the proposed cuts in rehabilitation research in a fiscal year 1984 budget request that increases the medical system's overall research budget.

The DAV can't understand why research designed to benefit service-connected disabled veterans must consistently be treated as a stepchild in the VA's research programs. After all, aren't the

needs of wartime disabled veterans the justification for having VA medical research programs in the first place?

I know other factors are involved here. But those who established the research priorities in the VA don't seem to understand who the VA medical system was established to treat. Service-connected disabled veterans should be the highest priority throughout the VA health care system, including its research programs.

We feel the Federal hiring freeze and cost-cutting measures is the principal culprit causing an adverse effect on the veterans' health care. When a progressive loss of personnel continues without replacement, there is no way the system can function smoothly.

Because of a shortage of qualified personnel, the veteran is exposed to extreme and sometimes cruel delays before seeing a treating doctor, at times even on an emergency basis. There are longer lines at the pharmacy. There is less control of treatment folders. Many are misplaced or lost and are not available to the examining doctor. This becomes extremely important particularly when there is a new doctor assigned to the veteran and he has to start from scratch. Also, a consistent patient and doctor relationship is really never achieved because of a constant rotation of doctors.

The age old problem of lack of communication between patient and doctor continues to exist primarily because of the language barrier. In the field of evaluation for compensation or pension, many doctors are not familiar with the procedures to be used for rating purposes, thereby creating inadequate examinations.

The DAV was most instrumental in having post traumatic stress disorder recognized as a medically accepted disability, but now encounters some resistance from some doctors to accept this as a bona fide rateable entity. We have only lightly touched on the subject matter, but we feel warmly confident that Congressman Edgar, in his capacity, is cognizant of the seriousness of the problems that exist and through his efforts a vast improvement will be made.

In regards to the current outpatient facility at North Chicago Medical Center, the DAV of Illinois is in full support of the construction of a centralized outpatient clinic on the current grounds of the North Chicago Medical Center. However, due to the cost factor involved, based on the historical designation of current buildings, consideration should be given for the utilization of cost sharing with the Department of Defense and mainly five floors of the U.S. naval hospital in Great Lakes, which are standing basically idle. It is felt greater emphasis in the geographic and improved outpatient facility would facilitate a higher quality of care to the disabled veterans.

This concludes my testimony, Mr. Chairman. I wish to thank you and the members of the committee for permitting us to provide our views on hospital and health care on behalf of the disabled veterans in the Great Lakes region.

[The prepared statement of Mr. Blechman appears on p. 118.]

Mr. EDGAR. Thank you, Mr. Blechman. I appreciate your testimony and appreciate your presence here.

We will move to our next witness, and we will save our questions until all of the service organization witnesses have spoken. Perhaps the AMVETS would like to come to the table at this point and we'll have all of our full panel here.

Let me ask now for Patrick De Mauro from the Veterans of Foreign Wars to speak. We have all of your statements here in front of us, and if you could summarize it would be helpful to give us an opportunity to ask some questions because of the pressure of time.

STATEMENT OF PATRICK DE MAURO

Mr. DE MAURO. Yes, sir. Thank you very much, Mr. Chairman. You have my remarks and there is no sense in reading them.

Just simply, you have the statistics, too, and we are aware of the fact that we have an aging population on hand. The future of the Veterans' Administration will have to, of course, change to meet their needs.

A lot was said today between the committee and the discussion they had with the deans of the medical schools. I am not totally convinced that all of our needs—the needs of the Veterans' Administration and the needs of the consumer—will be served by medical schools unless they themselves will alter their mission and more or less cooperate with the mission of the Veterans' Administration. Although their style is more or less in research and teaching of medicine, there is a great deal that is going to be enhanced in the future care by geriatrics, physical medicine, health maintenance, and services of that type, including, incidentally, alternative care. Not all care should really be made in VA hospitals. You have a lot of nursing care patients at home that perhaps could be served with medical teams, patients who would prefer staying home as opposed to being institutionalized.

Nothing was said so far about the process that the Veterans' Administration has recently established known as MEDIPP. It is the medical district initiated planning program. It is a study at the grassroots level to implement ways in which the Veterans' Administration can better serve the veteran population. I think a lot will come from that study.

I want to compliment the Veterans' Administration for locating the clinic at Crown Point, Ind., and I also want to thank this committee and the chairman for listening to me.

Thank you.

[The prepared statement of Mr. De Mauro appears at p. 122.]

Mr. EDGAR. Thank you very much for the summary of your statement.

I might mention before we go on that the MEDIPP process is under evaluation at this point. The first stages of that have been completed and this committee plans to have oversight hearings in Washington on that issue. Because we didn't deal with it today—and I appreciate your raising it—does not mean that we are not really interested in looking at that grassroots effort.

Mr. Duncan, representing the Paralyzed Veterans of America, we welcome you here. We appreciate your testimony. You perhaps may want to make recognition and introduce those who are with you, as well as give your statement.

STATEMENT OF THOMAS A. DUNCAN, JR.

Mr. DUNCAN. Yes. With your leave, Mr. Chairman, I would like to introduce our vice president, Mr. Hollis Hawkins. Next to him is Mrs. Shirley Rohwedder, the secretary and research director of the Vaughan Chapter, PVA, and next to her is George Dempsey, director for our Vaughan Chapter, PVA.

Mr. EDGAR. Thank you.

Mr. DUNCAN. I will try to make this brief, Mr. Chairman.

Mr. Chairman and members of the subcommittee, Vaughan Chapter of the Paralyzed Veterans of America appreciates this opportunity to present its views on the health care delivery system here at Hines VA Medical Center. Vaughan Chapter is one of the 35 member chapters of the national PVA. As with all PVA members and chapters, we are veterans who have experienced spinal cord injury or dysfunction, and due to that experience and dysfunction we have considerable contact with the Hines VA Medical Center health care system and the supplemental facilities and other extended medical health care services provided by the Veterans' Administration.

We will not concentrate on the Veterans' Administration health care delivery system in whole, since you have been privy to the statement of the national PVA. We will try to concentrate specifically on the problems and solutions on some of the issues that are germane to this facility.

There are seven issues we wish to address in our text: Long-term care here at Hines; the geriatric SCI veterans; personnel shortage, recruitment and retainment; pharmacy, delivery of medical supplies and medicine; SCI orientations; female veterans; and medical school affiliation.

The long-term care problem here at Hines was precipitated by the patronage system—I should say the paternalistic system—fostered some years ago, approximately 40 years ago, whereby the SCI veteran was not intended to live for a long period of time. However, through advancements in medical technology, some of those same SCI veterans are still living today. Thus, in spite of the non-existence of a major war, the SCI veterans population has grown and, according to statistics that we have seen, it will continue to grow. Therefore, we are faced with not only the young long-term SCI veteran, but the geriatric veteran as well.

Through negotiations with this facility and VACO, PVA negotiated and obtained permission for a long-term care facility to be constructed here at Hines VA Medical Center. However, due to budget cuts and rumors that we had heard, this facility is in jeopardy of not being constructed. In the interim period, in waiting for the construction of a long-term care facility, we were faced with the problem of what to do with the long-term care veteran until this facility was constructed. We received permission and got authorization for the placement of 16 of our veterans in the present long-term care facility here, located in this building.

However, we were promised that we would receive seven trained staff members to care for those SCI veterans while they were in that facility. To date, we have not seen those seven personnel placed in that center.

I would like to emphasize to this committee that if we do not provide the care and the personnel to provide the care for the individuals in that unit, we have defeated our purpose, and that purpose is to provide the best possible medical care for the SCI veteran.

Today we offer you solutions. No. 1, to insure that the long-term care domiciliary promised to this facility be built with all expedience and adequately staffed——

Mr. EDGAR. Would the gentleman yield at that point?

Mr. DUNCAN. Yes.

Mr. EDGAR. I appreciate the gentleman's comment. There were some rumors and some feelings that the spinal cord injury center was not in the 5-year plan of the VA. We have done some checking and discovered that not only is it in that 5-year plan, but construction is planned to begin in the 1985 fiscal budget. So your point No. 1 in your statement here, at least that rumor has been dispelled and the spinal cord injury commitment is in the 5-year plan.

Mr. DUNCAN. Thank you, Mr. Chairman.

Point No. 2. In the interim period, provide us with the funds to increase the staff or to add the staff necessary to sustain the individuals while they are in the existing nursing home unit.

Point No. 3. To seek and provide other alternatives for the SCI long-term care population.

We are well aware that a 40-bed unit will not resolve the problems of the aging and long-term care veteran, so surely we must look for other alternatives. Some of those would be to increase and upgrade the hospital-based home care system, and No. 2 would be to extend the fee-based home health care program.

These two programs combined allow the SCI veteran and all disabled veterans to maintain a viable home environment in the community, and it would certainly enable those who are capable of working to become gainfully employed and, therefore, an asset to society. With all this, we also realize that there must be even more alternatives. Along with the VA medical center, we have worked closely with them to establish a community nursing home committee, which tasks are to identify nursing homes in the community that may be able to provide the necessary care and extended care for the SCI veteran.

Also, a residential care committee was formed. Their tasks would be to identify those sponsor homes in the community that would be willing to take one or two veterans into their homes.

We realize, although we do not condone or endorse nursing homes, we realize there is a need for these facilities, and if they are properly and physically accessible and staffed, they will be an asset to the VA. However, we want to caution this committee, as you pointed out, that we need long-term care domiciliary and a viable VA hospital-based home care and fee-based program.

Going on to the aging population, this Nation, as a whole, is experiencing some problems with the geriatric veteran. Inclusive in this are the aging SCI veterans. Unfortunately, with the onset of age in the SCI veteran, we have seen an increase in fractures and breaking of bones, sometimes resulting in amputation. We have also seen an increase in decubitis, respiratory difficulties, cardiovascular disease, and other problems. Consequently, we would like to see an in-depth investigation as to why this is occurring and

what can be done to avoid them. The Vaughan Chapter also suggests that PT, OT, and skin care, as well as therapy be increased for the aging and geriatric veterans.

In regard to personnel, for years SCIS has always lacked an adequate amount of personnel and adequate trained personnel. We are well aware that physicians, RN's and LPN's are greatly underpaid by the VA compared to the private sector. This does not offer an incentive for these individuals to remain in the system. We must look at the salary range of our health care professionals and make them commensurate with their counterparts in the private sector in order to offer incentives to remain in the VA medical system.

Moreover, the SCI patient who is exposed to more nursing assistants than he is to physicians, RN's or LPN's, is subject to receive inadequate care due to the shortage of these individuals, not only in the nursing home unit, but also on SCIS itself. It is a common practice among these individuals, once they have been recruited and trained to SCIS, to seek transfers to other units within the hospital or even other services who offer higher pay for less work or an opportunity for advancement. The VA must offer pay scales comparable to those of private sectors. They must also offer other gratuities for the retainment of these individuals. They must improve their hiring practices, recruitment, and also their retainment techniques.

Our next concern is orientation to the SCI veteran. Often our veterans go to other floors with other medical problems such as surgery or what have you, and they return with bladder or other infections which could have been avoided if that individual were orientated on how to care for the SCI veteran.

To compound this, we have witnessed discriminatory attitudes toward the SCI veteran because other individuals placed emphasis on his drug and alcohol problems. Vaughan Chapter admits that some drug and alcohol abuse exists, and in the same vein it has questioned and suggested several times that a drug abuse and alcohol program for the SCI veteran be established.

Edward J. Hines Medical Center has, in conjunction with PVA, conducted several seminars designed to educate both the community and in-house personnel as to the ramifications of SCI from the acute stage through placement back into the community. We would like to see more of these type of seminars in the future. But again, we're dealing with the problem of the budget crunch.

Expounding further on the lack of knowledge on the SCI veterans' needs, the ramifications of his injury has overflowed into the pharmaceutical department.

The SCI outpatient requires specialized equipment, medicines, and supplies on an ongoing basis germane to his injury that are not common to other types of disabled veterans within the medical system. The timely delivery of such items as catheters, external catheters, and other life-supporting supplies and medicine is paramount for the day-to-day existence of this veteran.

This problem can be attributed not only to the lack of knowledge of those medical personnel dealing with the delivery of these supplies, but also due to the fact that the budget restraints often curtail or prohibit the issuing of this equipment.

Next to last, but not the least, is the problem of the female SCI veteran. In the past, this worthy individual was passed off to other private sector hospitals or affiliated medical facilities. However, as statistics have shown, there has been a marked increase not only in the female veteran coming into the VA system, but the SCI female veteran coming into the VA system. We can expect, with the increase of women in the service, and an increase in leisure time which fosters these injuries, more female veterans will come into our medical system. We must find some means to accommodate and provide adequate medical care for this female population.

In conclusion, gentlemen, I would like to express to this body that we have experienced and will continue to experience a good working relationship with the administration of this medical facility. Though we may not always agree, we somehow manage our conflicts and make the proper decisions for the betterment of all the veterans. To this end we will continue to work, but we would like to leave you with this thought: It does not matter on how many solutions and alternatives we develop here in the field; our problems cannot be resolved unless we are authorized by the VA central office and properly funded by the U.S. Congress to carry out our programs. The obligation that we have to veterans is one that we must all share and that we must all be held responsible for if we waiver from our obligation.

Mr. Chairman and members of the subcommittee, this concludes my statement. On behalf of the Vaughan Chapter of PVA, I will be glad to answer any questions you may have.

[The prepared statement of Mr. Duncan appears at p. 126.]

Mr. EDGAR. Thank you, Mr. Duncan, for your very comprehensive statement. The full text of your statement will be made a part of the record. We really appreciate your summarizing that statement for us.

We will now hear from the American Legion, Mr. John Cryan.

STATEMENT OF JOHN CRYAN

Mr. CRYAN. Mr. Chairman, you have a copy of my statement so I won't read it, but I would like to go back to your opening remarks and to the directors of the hospitals, and to Mr. Moore, that that's the name of the game, money. We have the highest amount of moneys the VA has ever received, as Congressman Hammer-schmidt said, but the percentage is lower. We are getting less than 3 percent of the total budget and that's it. We need more than 3 percent to carry on the health care and preventive medicine, as Mr. De Mauro said. I agree with him wholeheartedly. That is it, the bottom line. The hearings and the testimony, it comes right back down to money, money, and more money.

The hospitals in this area, you figure there are 1.4 million-plus veterans in Illinois, you've got 737,000 of them in Cook County alone, and when you cover the counties in northwest Indiana, you're talking about over a million. They have to come somewhere in these hard economic times. They are looking to the VA for help.

Mr. Fears said the most complaints he gets is from the non-service-connected veterans when they are off the program. We hear that daily. I am in the field 5 days a week. The American Legion

employs a full-time employee at all the VA hospitals in Illinois, and we have a part-time employee at the outpatient clinic in Peoria. We are in daily contact with and have weekly reports from them. This is a major problem throughout Illinois, the turning away of these people.

Here's medicine for 30 days; go see your own doctor. Well, if the man was working and he had hospitalization, he would see his own doctor. He probably wouldn't be coming in here. Westside alone now is getting 480-some new people per month for ambulatory care and inpatient care. With the moneys they have, these directors are very dedicated people at these hospitals, and so are their staffs. I am very impressed with them. I, myself, am a service-connected vet and I am treated at Westside Hospital. With the moneys they have allocated to them, they are robbing Peter to pay Paul, as they said. We have to give them all our support and all our help. Just to sum up, it goes right back again to money.

Thank you.

[The prepared statement of Mr. Cryan appears at p. 138.]

Mr. EDGAR. Thank you very much for your summary statement.

Our final witness is Mr. Harlan Keppel. We appreciate your being patient with us all day today.

STATEMENT OF HARLAN KEPPEL

Mr. KEPPEL. Mr. Chairman and members of the subcommittee, we thank you for allowing AMVETS the opportunity to testify before this Subcommittee on Hospitals and Health Care for our veterans in VA hospitals.

It is becoming very apparent in our dealings with the VA hospitals in the Chicago area that was AMVETS are quite concerned over the lack of health services being provided as promised to all our veterans in the VA hospitals.

Regardless of the type of disability, service-connected or non-service-connected, treatment must be available to the eligible veterans who seek help in a VA hospital.

World War II veterans are requesting admission in great numbers due to the economic conditions, and many veterans of all ages are now requesting admission to VA hospitals. Unemployment, coupled with the loss of hospital insurance coverage, has forced these veterans to seek admission to the VA hospitals. It is becoming quite apparent that due to the heavy workload of patients, the VA hospitals are severely short of funds to handle the overload.

The VA hospitals were prepared for the World War II veterans, but all veterans seeking admission has caused this backup in services. When a veteran served his country, the Government promised hospital and health care for him. This promise must be kept.

Medicare and medicaid cutbacks are causing many veterans to go to VA hospitals for treatment, but non-service-connected veterans seeking medical attention are given 30 days medication and told to go to their private doctors for assistance. The service-connected veterans seeking non-service-connected treatment are also being told to see their private physician.

The VA hospital pharmacy units at Westside VAMC and Hines VAMC are filling out over 12,000 prescriptions per week with an ever-increasing volume. This gives you an idea of the workload.

In closing, funds must be provided to the VA medical centers to be able to give this health care to the deserving veterans as promised by the Congress of the United States.

Again, Mr. Chairman, to reiterate Mr. Moore's remarks, money, money, money. It seems to be the answer to everything that is wrong in this world. If we have it, we want more. If we don't have it, we want some.

Care is the big thing for the veteran. It has been brought to my attention recently that the alcoholic rehabilitation program here at Hines has been cut from 120 days down to 30 days. It is hardly even time enough to start out. That's just a side comment.

I thank you again for the opportunity to appear here and to present our testimony.

Mr. EDGAR. Thank you very much.

Let me yield to my colleague, Mr. Hammerschmidt.

Mr. HAMMERSCHMIDT. I am not going to ask any questions. I am just going to make a few closing comments because of the time.

Let me say, Mr. Blechman, that there was one item was of concern to all of us. It concerned research and development money in the medical care program. But let me say that the House and the Senate both have added about \$6 million back into that program, which I hope will go somewhat toward alleviating our concerns about that.

To all of you, all the service organizations, your work in the service officer area is legendary. We know that all of you have helped hundreds and hundreds of thousands of veterans. But here in this area you are also noted for the volunteer work that you do in the hospitals, so I want to commend all of you and the people in your organization, the auxiliary, all of them that work so hard at that. It is something you can't buy and it is very meaningful.

You know, we work daily—and I mean literally daily—with your counterparts, your staff in Washington. We couldn't get along without them. They are such an inherent part of our Veterans' Affairs Committee's activities and work that we want to express our appreciation to them through you, because, of course, they get their mandate and their support from you and your departments and posts, your resolutions that you pass at your national conventions. So we very much appreciate your being here today with your testimony.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Keppel appears on p. 140.]

Mr. EDGAR. Thank you.

Dr. Rowland.

Dr. ROWLAND. I have no questions, Mr. Chairman, but just to comment that I am very grateful to all of you for having come today and for all that you do to help the veterans in our country. I appreciate it very much.

Mr. EDGAR. I, too, want to thank each of you and give you each a little challenge. I associate myself with the remarks of my colleagues, Mr. Hammerschmidt and Dr. Rowland, about the service that you as individual service officers give to your organizations.

I would challenge you to really work very closely with your staffs in Washington, who work with us on a day-to-day basis, passing legislation and monitoring bills and pieces of legislation that already have become law. We are going to live in difficult days over the next several years. The commitments that we have made in terms of expenditures in defense, the cutbacks that have been made on the domestic side, the pressures from the tax cuts that have been made, the focus on the attention of the high deficits, cause all of us a great deal of uncertainty each year when the veterans' budget is up.

During the first 2 years of this administration the House and Senate Veterans' Affairs Committees I think acted responsibly in fighting some areas that the administration wanted to cut. And regardless of whether it is a Democratic or Republican administration in Washington, the veterans' area stands out as an area where there is some discretion and where you can make some attempts to cut back on services, as was mentioned by our last witness.

We really need your help in demonstrating to other Members of the House and Senate, and to our colleagues at the White House and in the Office of Management and Budget, and within the VA, of the importance of the veterans' health care system throughout the Nation, its adequacy, its quality, its quantity, its need for the future. Without the help of the service organizations, we simply could not get the support that we count on in the House and Senate to make sure that we mandate the level of service and that we keep the commitment.

As Mr. Hammerschmidt pointed out, we are launching on one of the largest renovation and construction programs in the history of the VA in trying to replace and renovate aging veterans' facilities, rehabilitating those facilities that exist that aren't meeting the health care needs for veterans. If we don't do a good job in that area, we will find ourselves 10 and 15 years down the line with not just obsolete facilities but facilities that simply are unusable. Now, we need your help in keeping the pressure on in Washington, to make sure the commitment to veterans stays secure. So thank you again for your testimony and for your help.

Before we close today, I would like to also thank a number of other people. I would like to thank the American Legion Auxiliary, the Military Order of Purple Hearts, the AMVETS Auxiliary and other organizations that have made a contribution to our hearing today by providing refreshments, by providing lunch and flowers and an opportunity to make these hearings very meaningful.

I would also like to compliment the people in the Office of Legislative Affairs in Washington, particularly the Navy Director, Capt. Peter Cressy and Lt. George Busse and Ens. Mark Carlson who have been assisting our committee. I would also like to thank the Navy Office of Information in the Chicago area, the Director, Lt. Comdr. Chuck Connors.

I would also like to thank the Navy Training Center in the Great Lakes, Ill., area, commanding officer, Capt. Charles Highland, and the public affairs officer, Lt. Susan Wyman. The Navy hospital at Great Lakes has also been a help to us. The commanding officer there is Capt. Joseph Rizzoto.

I would also like to pay special tribute to the people around me and beside me and in back of me, who are the committee staff, counsel, and my personal staff, who have provided background for the hearings today. They do a great job in Washington and are hidden behind the scenes; yet it is important to have their presence here.

To all of you in the audience who have come, let me just say we appreciate your attendance. We also know there are some in the audience who have statements and comments that they would like to make. We would be glad to receive your testimony for the record. We do not have the time today to take individual comments.

I will recognize the gentleman who is standing, as he is in uniform today with his hat—would the gentleman come to the microphone and announce who he is and make his comment.

Mr. SHEEHAN. My name is Hal Sheehan. I am the service officer for the American Ex-Prisoners of War. I represent the State of Illinois as service officer and am past national director.

I want you to be advised that there are over 2,000 POW's in the State of Illinois, and more than half of them are in this area.

I would direct a question to you and ask you, as we are a national organization and a congressionally chartered organization, why were we ignored an invitation to participate today?

Mr. EDGAR. Obviously, it was simply an oversight by myself and I take full responsibility for that. We will make sure that in our field hearing in Boston that we are having later, early in the month of August, or our field hearings in Florida or California, Texas, that we will make sure your service organization is invited.

There are a lot of other service organizations that are present here—the Jewish War Vets and others. It is not an intentional oversight. It is merely, in some instances, a matter of time. In other instances, some of the organizations have affiliations with other organizations. I am not sure that anything that could have been said differently was not shared by the service organizations that were represented, but I apologize to you publicly for not extending to you a personal invitation. When you hear of our committee being in this area again, yell and scream and holler and we would be glad to have your testimony.

Let me say to all of you who have comments and testimony from other organizations, Vietnam veterans organizations, prisoners of war organizations, the Purple Heart Association, those who are concerned about atomic veterans, please communicate with our committee and we will make your statements a part of the record. We apologize for the oversight of not giving each of you a personal invitation, but sometimes it is a matter of oversight and sometimes it is a matter of simply time to commit to the number of witnesses. We would have liked to have heard from everyone in the audience, but it is just not possible.

Mr. HAMMERSCHMIDT. Mr. Chairman, would you yield a moment?

Mr. EDGAR. I yield to the gentleman.

Mr. HAMMERSCHMIDT. I just sort of want to repeat what you said and to reiterate and try to reassure the gentleman who spoke from the POW organization, that your testimony submitted—and the record will be open for a while—will receive exactly the same equal

weight and consideration in the written record as if it were given verbally. I just wanted you to know that.

Mr. EDGAR. Thank you very much. We hope you have a pleasant day.

The hearing is adjourned.

[Whereupon, at 1:45 p.m., the subcommittee was adjourned.]

APPENDIX

PREPARED STATEMENT OF HON. LANE EVANS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

As the only Illinois Representative on the Subcommittee on Hospitals and Health Care of the House Veterans' Affairs Committee, I welcome each of you to this oversight hearing on the VA's health care delivery facilities in the Great Lakes region. My hat is off to the Chairman for his ceaseless efforts on behalf of all veterans in this country.

I am pleased to be back in my home state today, especially in the Chicago area, to see the operations of the Hines VA Hospital facility and to discuss matters of importance to veterans. I firmly believe that these field hearings are the very best means by which Members of Congress and other interested parties can adequately discuss and implement pertinent legislation.

Judging from the fine representation here today, including our distinguished colleague from Illinois, Congressman Paul Simon, it appears that many others feel the same way.

As a former member of the U.S. Marine Corps, I am deeply committed to the welfare of the veterans of this nation. I believe that no group is more deserving of a dignified and honorable place in society than is the veteran community.

To express this commitment, I made it my first priority last winter to gain a seat on the Veterans' Affairs Committee and to be placed on the Hospitals Subcommittee which has jurisdiction over the health care functions of the Veterans Administration.

As you all may know, the Subcommittee has been very active in recent months, developing legislation to provide necessary funding for the VA's health care program and other benefit programs. This legislation has been enacted by the Congress as the will of a grateful nation for the sacrifices these veterans have endured in serving in the armed services.

Among the proposals which the Subcommittee has considered during the 98th Congress, none has held more immediate importance than H.R. 2920, the Veterans Administration Health Programs Amendments of 1983. This measure includes provisions to:

- (1) Extend the Veterans' Readjustment Counseling Program by three years,
- (2) To initiate a comprehensive study of the readjustment problems being encountered by Vietnam Era veterans,
- (3) To establish an Advisory Committee on Women Veterans,
- (4) And to increase the VA per diem rate payable to state extended care facilities, was passed by the House of Representatives on May 23. Similar legislation is currently awaiting action in the Senate.

I might add that the Chairman of the Veterans' Affairs Committee, the Honorable Sonny Montgomery of Mississippi, has assured me that should this legislation go to conference, the House conferees will do all they can to ensure passage of the House version of the bill.

I may also mention that I have a particular interest in the provision to extend the highly successful Vet Center program. Having introduced H.R. 2323, a measure which was subsequently merged into the full committee report, I would like to take this opportunity to briefly underscore the features of this program.

Since 1979, the VA has offered readjustment counseling and related mental health services for Vietnam-era veterans experiencing readjustment problems resulting from their Vietnam service. By design, the centers were established separate from traditional VA health care facilities.

The program provides low-key professional outreach and counseling services in storefront locations across the country, and serves approximately 80,000 Vietnam-era veterans this year at a cost of around \$5 million (about \$60 per veteran).

The readjustment counsel program is based on evidence that a significant portion of the Vietnam-era veteran population continues to experience mild to severe stress reactions resulting from their military service. The American Psychiatric Association has formally defined this disability as Post Traumatic Stress Disorder or PTSD.

In this regard, I am very pleased to have as one of our guest witnesses today Ms. Lori Johnson of Moline, Illinois. Ms. Johnson, who happens to be one of my constituents from the 17th District, has generously agreed to take time out of her busy schedule in order that she may relate to us some of her personal experiences with PTSD.

In a major survey of Vietnam-era veterans conducted five years ago, the Center for Policy Research in New York found that 600,000 to 700,000 Vietnam-era veterans were still experiencing readjustment difficulties associated with Post Traumatic Stress Disorder.

Other studies have found that the type of peer group counseling provided by the storefront "Vet Centers" is the most effective means of identifying those experiencing PTSD and treating the problem. Considering that nearly one-third of the 136 Vet Centers have been open less than a year, it is clear that the need for readjustment counseling is far from over.

Finally, I'd just like to point out my sincere interest in providing all generations of veterans the quality and quantity of health care which they have earned and deserve. It is my hope that the Veterans Administration will always respond to the changing nature of the veteran population and accommodate these particular needs, whether they be in reference to veterans of World War I or the Vietnam Era.

Of all the benefits afforded America's eligible veterans, it is my opinion that health care is the most important. Because of this importance and our commitment to provide health care to veterans, it is this Subcommittee's responsibility to ensure that the VA's machinery is in place and constantly being revised to reach its primary goal.

I look forward to reviewing the programs and facilities here in the Chicago area, and again I thank the distinguished Chairman, Mr. Edgar, for providing this opportunity and for his constant dedication to this nation's veterans.

STATEMENT OF A. ZAMBERLAN, REGIONAL DIRECTOR, GREAT LAKES REGION,
DEPARTMENT OF MEDICINE AND SURGERY, VETERANS' ADMINISTRATION

Mr. Chairman and Members of the Subcommittee, we appreciate having you join us today in Medical District 17. The primary mission of every VA Medical Center is the provision of highest quality health care to our nation's veterans. We in the Great Lakes Region are committed to this mission, though we recognize as well the additional imperative of offering quality services in a cost-effective environment. Four VA medical centers—the Edward Hines, Jr. Hospital and the Lakeside, North Chicago and West Side VA Medical Centers—comprise Medical District 17 which is the most complex medical district in this Region. Four medical school affiliations, urban economics, and a full spectrum of health care are among the factors which give Medical District 17 a distinctive profile. As will be discussed further, perhaps no other configuration of VA facilities in the country better exemplifies the system's strengths and vulnerabilities.

Today, the metropolitan Chicago medical centers serve a population of 994,000 veterans who reside in 17 northeastern Illinois and 6 northwestern Indiana counties. Thirty-six percent of this population is under 45 years of age while fourteen percent is over age 65. By 1990, the estimated veteran population will decrease ten percent to 900,000. The portion of veterans over age 65, however, will increase nearly twofold to 24 percent of the population. Approximately 36,000 female veterans currently reside in the Chicago primary service area and were responsible for 455 discharges during fiscal year 1982.

The four Chicago medical centers have a total complement of 3,830 authorized beds which includes 430 VA nursing home beds. The 7,838 full time employment equivalent (FTEE) employees include 1,272 FTEE registered nurses and 392 FTEE physicians. Medical school affiliations increase physician staffing levels by 438 FTEE house officers. Medical District 17 is fortunate at this time to have minimized any nurse recruitment and retention concerns.

Workload and productivity measures show the Chicago medical centers to be among the most active in the system. Overall, the hospitals maintain an occupancy rate above 80 percent with one facility averaging close to 90 percent occupancy. The total number of patients treated in the first eight months of this fiscal year is over

36,000 for the four hospitals. 467,000 outpatient visits were accomplished during the same eight-month period. Noteworthy is that the patients treated and outpatient visits are exceeding planned levels by nearly 8 percent. The Medical District is current in the processing of Agent Orange examinations and has appointed a physician coordinator for the POW health assessment program.

The fiscal year 1983 medical care budget for Medical District 17 is just under \$300 million. In addition, the four medical centers have over \$7 million in VA-funded research. These programs include significant initiatives in medical, rehabilitation, agent orange and health services research.

The fiscal year the medical centers will accomplish projects totaling \$6.2 million in the nonrecurring engineering maintenance and repair program. In addition, \$2.6 million in Jobs Bill funding will support another 17 M&R projects in the district.

The Chicago area hospitals continue to be recognized among the most progressive medical centers in both the Region and the Agency. For example, the Hines VA Hospital has been in the forefront of the Department of Medicine and Surgery's decentralized ADP initiative and has been designated as a Verification and Development Center. Hines also has a proud history in rehabilitation delivery programs. Reflecting this are two distinguished programs—spinal cord injury and blind rehabilitation. The District's strategic planning process (MEDIPP) identified the increasing importance of special services for the aging veteran. Recent accomplishments in geriatrics already include the activation of a new nursing home care facility at Hines, a locally acclaimed senior adult center at North Chicago and the participation of the Lakeside VA Medical Center in a new interdisciplinary center on aging at the McGaw Medical Center.

The role of Medical District 17 in utilization of sharing legislation has been significant. It is our belief that the implementation of Public Law 97-174 which authorized VA/DOD sharing will enhance sharing opportunities because of the incentives dealing with reimbursement availability at the local level. Under the existing sharing legislation, an agreement between the North Chicago VA Medical Center and the Great Lakes Naval Regional Medical Center covers services such as laboratory and radiology. Sharing of additional services is currently being pursued.

The Medical District 17 track record both in delivering patient care services and participating in new programs and initiatives has been sustained through conscientious management and adequate resources. Future successes, however, are dependent on the district's ability to meet and overcome the challenges of an eroding resource base. The issues are not only budgetary, but also include the dilemmas caused by pervasively poor economic conditions throughout the Great Lakes Region, facility aging and structural obsolescence and the specter of the return of recruitment and retention concerns in the federal work force. In response to these challenges, the Region has been a leader in the development and testing of new casemix oriented resource allocation methodologies. These formulas are designed to stimulate management efficiency and to consider the acuity, as well as the quantity of care rendered.

Improved sensitivity in the allocation of recurring funding, however, will address only one set of issues. Nonrecurring renovation and construction projects are also critical to the future of the VA's health care delivery system. In Medical District 17, for example, significant clinical improvements are being planned for the next several years and include such projects as:

A \$10 million, 120-bed nursing home care addition at Hines; a \$7 million, 40-bed long-term spinal cord injury unit at Hines; a \$44 million, 180-bed psychiatry facility replacement at Hines; a \$36 million outpatient addition and renovation at West Side, and a \$48 million series of environmental improvements in patient and nursing home care buildings at North Chicago.

The age of many of our facilities—some in this Region date back to the Civil War—preclude their adaptation for new technologies. In some instances, their condition falls below the desired life safety code standards for patient care. Unfortunately, outdated facilities may confound delivery system efficiency and ultimately compromise the quality of care.

Finally, while MEDIPP has given us the tools to predict future demand based on demographic data, we have no tools to predict future demand influenced by economic trends. The Great Lakes Region has been perhaps the hardest hit by unemployment and its consequences. Informal studies conducted this winter and spring here in Chicago show a steady and significant increase in new consumers in the VA system. One hospital reports that as many as 30 percent of its applicants have not utilized VA health care services in the past three years and may never have used VA services. We believe that many of our new consumers are unemployed, and now uninsured, veterans who previously received their health care in the private sector.

State reductions in Medicaid funding and pending changes in the Medicare reimbursement structure as defined by Public Law 97-248 and regulations subsequent to the Tax Equity and Fiscal Responsibility Act may be encouraging private sector providers to instruct individuals to utilize their veteran benefits. We are continuing to study more rigorously the extent of consumer influx; however, the full impact of the economy's shifts will remain difficult to assess.

In concluding my remarks, I wish to express my appreciation to the Subcommittee for this opportunity to discuss the Veterans Administration health care system in Medical District 17. We in Region 4 look to the future confident that we will be able to continue to deliver high quality services to our veterans. As managers, we view the challenges as pathways to innovation and improved performance. We are proud of our medical centers, our dedicated staffs, and our volunteers and we welcome you to Chicago. This concludes my statement, Mr. Chairman. My colleagues and I will be pleased to respond to any questions that you or members of the Subcommittee may have.

[Subsequently, the Veterans' Administration furnished the following information:]

Department of Medicine
and Surgery

Washington D.C. 20420



Veterans
Administration

August 26, 1983

In Reply Refer To: 10BA4

Honorable Robert W. Edgar
Chairman, Subcommittee on
Hospitals and Health Care
House of Representatives
Rayburn HOB, Room 2352
Washington, D.C. 20515

Dear Mr. Edgar:

Thank you for this opportunity to share our vision of the Veterans Administration in the year 2000. The following comments reflect not only my personal views, but also incorporate the thoughts of the 25 Medical Center and Clinic Directors in the Great Lakes Region. I know that in several instances the Directors consulted with both clinical and administrative staff in order to expand the perspective of the statements they forwarded to me.

First, I believe it is important to define some of the basic parameters of our thinking. As guidance for the Medical District Initiated Planning Process (MEDIPP), the Chief Medical Director provided the field with a set of overview "assumptions." Two of these—that there will be no new wars and no national health insurance program implemented between now and the year 2000—are fundamental to this discussion. I have no doubt that these two assumptions are generally held in the private health care sector as well. Further, we believe that the same economic, political, technological, social, and ethical factors which will influence the private sector's future will be influencing the course of events for the VA. Only the demographic factors affecting the VA will be unique to the system.

The VA cannot now, or in the years to come, be analyzed and described outside of the total national health care context. The VA's health care delivery system is neither tangential nor parallel to the private sector delivery systems, but rather is interactive and integrated with them. Thus, we are inheriting the same legacy of past practices—e.g. rising costs and rapid technological advances—as the private sector and we can expect to participate jointly in confronting the challenges now on the horizon.

The majority of my discussion on the VA's future will be addressed in six sections: (1) consumers, (2) management and delivery system organization, (3) human and financial capital, (4) education, (5) research, and (6) new directions. While each section appears to describe an independent set of concepts, the discussions are not meant to suggest that the issues are mutually exclusive.

Honorable Robert W. Edgar
Washington, DC

CONSUMERS

The demographers definitively tell us that our clientele is aging. Clearly over the next two decades the VA will become proficient in the care of the geriatric patient and in the treatment of the constellation of chronic diseases which afflict the elderly. This experience will include the development of programs which enable such care to be provided in a humane and effective manner. By the year 2000 the geriatric veteran may be the system's primary consumer and will have stimulated the medical centers toward innovations in extended care systems and long-term support networks. The aging veterans utilizing VA services will include those retirees who "opt" to enter the system in preference to such programs as Medicare as well as those veterans who have received some or all of their health care through the VA during earlier stages in their lives.

The economy, particularly the size and stability of the work force, will be a critical factor in determining the VA's future consumers. High levels of unemployment, reductions in the health care benefits of workers, and the availability of a comprehensive delivery system will encourage younger veterans to draw on their VA eligibility. The trend in Medicare of beneficiaries paying an ever increasing proportion of their bill may lead VA eligible Medicare beneficiaries to avail themselves of our system to a greater extent. Distinctions between service-connected and nonservice-connected eligibility will become less discernible, particularly as the large numbers of service-connected combat veterans age. Specifically, without combat, fewer veterans will demonstrate true "service-connected" diseases and disabilities. VA eligibility, as legislated by Congress, may broaden and evolve as a post-military service benefit which is offered as an armed forces recruitment incentive.

As a result of the infusion of younger consumers into the VA health care delivery system and of a trend toward comprehensive, rather than selective, use of its services, the VA will retain its acute care focus and the full breadth of its mission. The challenge now is to ensure that the delivery system structure is sufficiently flexible to be responsive to shifts in the demographics, economics, and health status of the consumers.

MANAGEMENT AND DELIVERY SYSTEM ORGANIZATION

Over the next 20 years the VA, like other multi-hospital systems, will streamline its operations and eliminate the inefficient and non-essential elements of the corporate infrastructure. For example, fewer medical centers will offer comprehensive services; acute care facilities will be smaller, and rural facilities will become focused providers of primary and long-term care in settings close to the veteran's home community. However, the integrity and scope of the VA health care delivery

Honorable Robert W. Edgar
Washington, DC

system will not be compromised, but rather will be enhanced through the regionalization and consolidation of both management and services. In addition, an expanded referral and transportation network will augment the coordination of patient services.

The medical districts will be the focal point of regionalization. Computer systems at each medical site will facilitate communication and will be used extensively for remote diagnostic and treatment decision-making. The increased emphasis on the district will permit monitoring and control functions to occur where immediate corrective action can be taken. Also, talents and skills of key personnel will be developed and shared among the district facilities, again at a level where a dynamic awareness of local circumstances can be maintained.

The number and type of sharing agreements will dramatically increase and will involve the cross-utilization of resources among VA's, other public and private community health care institutions. Improvements in cost efficiency and patient care effectiveness will result from expanded sharing arrangements, particularly in the utilization of rapidly advancing high technology.

HUMAN AND FINANCIAL CAPITAL

Resource issues will remain among the most critical concerns in the year 2000 for the VA's health care system. Cost efficiencies and economies of scale will be achieved through administrative consolidations, regionalization, improved methods of allocating recurring funding, and through the implementation of new and more effective treatment modalities. An emphasis on preventive health care and on ambulatory, rather than in-patient, programs will further contribute to the appropriate and most effective utilization of resources.

Three resource areas will be noteworthy as the next 20 years unfold. First, difficulties in the recruitment and retention of physicians will become minimized as the fee-for-service and solo practice models yield to organizational patient care and economic advantages of group practice and as the supply of physicians grows. The VA health care system with its secure salary base and large and interesting case mix will become a highly desirable and competitive practice alternative for physicians whether they seek an academic orientation or concentrated clinical involvement. Similarly, the availability of nursing and allied health staff will increase as private sector hospitals trim programs and personnel costs.

Second, the VA will figure prominently in the development and utilization of new technologies. Regionalization, sharing, and strong research initiatives will permit the VA's health care delivery system to demonstrate the cost and diagnostic and therapeutic advantages of new

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equipment and techniques. The system's investment in technologic resources will escalate, but will be guided by strategic planning for, and placement of, equipment and services.

The VA's facility resources will be noteworthy in the year 2000 by virtue of their decline. The obsolescence and deterioration of medical center buildings will be difficult to forestall. Where the private sector is now replacing structures built in the 1950's, the VA considers such structures as still relatively "new" in the 1980's. Renovations and modernizations will become increasingly more costly and the inability of the system to keep pace with its long-term construction needs will contribute significantly to the consolidation and regionalization processes. Medical center mission changes will result as unsafe or unalterable buildings are removed from use. Ultimately, the VA will seek alternatives to new construction such as the leasing or sharing of local health care facilities.

EDUCATION

The decreasing availability of scholarships and other forms of educational financing, along with cost-containment measures resulting in the elimination of professional training programs in many community hospitals, will place the VA in the forefront of medical education. Affiliations will be realigned and will be "regionalized" so that residents, for instance, may elect clinical rotations at any district facility. The number of students in the system will increase and virtually every medical center will have an active medical school affiliation. One outcome may well be that the VA will emerge as the primary source of direct federal support for medical education.

In the field of geriatrics, the VA will be regarded internationally as the "experts." The VA's educational leadership will extend to nursing and the allied health professions which will look to the VA for new training opportunities.

RESEARCH

The VA will continue to make profound contributions to scientific knowledge and to provide major support for significant research endeavors. Without compromising its excellence in laboratory research, the VA will pioneer in new investigative areas. For example, the changing demographics will afford the VA a unique opportunity for the development and demonstration of extended care alternatives to hospitalization. Similarly, increasing numbers of research initiatives will explore innovative methodologies addressing the organization, administration, and financing of health care services.

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Washington, DC

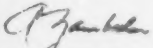
NEW DIRECTIONS

The VA's first priority will continue to be the delivery of high quality health care in a cost effective and humane environment. However, as discussed, the VA will have recurring opportunities to develop provocative and innovative new health care programs and to set the pace and direction for the nation. The VA, uniquely, has the potential for offering continuity of services to its consumers. Unlike the private sector which confronts the patient episodically and fragments its levels of care, the VA is a comprehensive delivery system with integrated ambulatory, acute, and rehabilitative care components.

The VA's challenge will be to raise its visibility and open up the system for scrutiny, and become a national model. The VA's health care delivery system will still explicitly not compete with the private sector, but will continue to be a viable and impressive health care alternative for eligible consumers.

We appreciate the chance to present our thoughts on the future. We are looking forward to the next two decades and beyond.

Sincerely,



A. ZAMBERLAN
Regional Director
Great Lakes Region

Medical Center

North Chicago IL 60064



Veterans
Administration

JUL 26 1963

In Reply Refer To: 556/002

Regional Director (10BA4)
Veterans Administration Central Office
810 Vermont Avenue, NW
Washington, DC 20420

SUBJ: Future of the VA Statement

As you requested I am enclosing a copy of my feelings concerning
the future of the VA.

DL McGee

D. L. McGEE
Medical Center Director

Enclosure

Veterans Administration Medical Center
North Chicago, Illinois 60064

FUTURE OF THE VA

During the next 20 years, there will be an increasing demand placed upon the Veterans Administration for acute medical and nursing home care. Not only is the number of persons in the general population over age 65 increasing rapidly, but the percentage of veterans in this district over 65 years of age is expected to grow by more than 100% between now and the end of this century. Older veterans require more medical attention than do their younger counterparts. Frequently older veterans have inadequate or no health insurance to fall back on in times of severe illness. Increasing health care costs and decreasing governmental expenditures for health services will further direct eligible veterans to our health care system for treatment. One area the Veterans Administration will need to carefully address is Nursing Home Care and the non-acute care of older individuals. Alternatives to institutionalization for older veterans such as Senior Adult (Day Care) Outpatient Centers, Hospital Based Home Care, Respite Care and others will expand. These activities should shorten the length of stay in acute beds and provide an environment in which veterans can continue treatment and/or rehabilitation while residing at home.

While nursing care is an issue, the Veterans Administration at the same time must not overlook the acute care needs of our veterans. The discharge rate and therefore the admission rate for all males in the United States increases from approximately 166 per 1000 population for individuals between the ages of 45 and 64 to 269 per 1000 population for individuals over age 65. This drastic increase in the need for hospitalization is even more pronounced for veterans here in Medical District 17. The discharge rate is almost double for veterans over age 65 than it is for those under 65. The VA must carefully organize its system to meet these acute needs.

Female veterans are, and will continue to be, a growing area of demand for VA services. Once the female veteran accepts the capabilities of the VA to care for her equally as well as community providers, more and more female veterans will turn to the VA for care. Resources must be provided to allow VA Medical Centers to adjust and adapt physical resources necessary to provide this care. To successfully implement Public Law 97-174 by sharing health resources with the Department of Defense (DOD) and be in a position to provide contingency backup to DOD, the VA will need to look more and more like community hospitals. The VA is in an unique position to do this given the strong affiliations with this country's medical school and the resources this school can and could make available.

Other groups of veterans who will need to be provided special attention are those experiencing Stress Disorders, those exposed to Agent Orange and those exposed to Ionizing Radiation. These and other groups will continue to increase the demand for VA health services.

In the future, we must tell the VA story more effectively to all segments of the American public. The VA conducts the largest coordinated health professions education and training effort of its kind in the world. In addition, the contributions to medical care scientific knowledge coming from VA research activities continue to be extolled. The involvement of the VA in the medicine of this country is far more than that of an "old soldiers home."

I believe the VA needs to examine the geographic placement of our medical centers and outpatient clinics. We might all profit from a more even distribution of health care resources throughout the country. Perhaps thought should be given at the time facility replacement is discussed to relocations of existing centers. The proximity of three large institutions here in Chicago is an example. The Veterans Administration must continue to change and grow to meet the demands of the coming year. History indicates that the VA has always successfully met its challenges. I fully expect the agency to meet the demands placed upon it now and in the future.

Edward Hines, Jr.
Hospital

Hines IL 60141



**Veterans
Administration**

August 11, 1983

In Reply Refer To: 578/00

Regional Director (10BA4)
Great Lakes Region
VA Central Office
810 Vermont Avenue, N.W.
Washington, DC 20420

SUBJ: Response to Congressional Challenge Regarding the Ability of the VA to Provide Quality Health Care to Veterans in the Face of Constrained Resources and an Aging Population Base

1. In response to Congressman Edgar's challenge to Senior VA Health Systems Managers to provide the highest quality health care to our veteran population some commentary has been assembled within the format of this letter. Of primary concern to the Congressman, and no doubt of primary concern to us in the VA, are the future effects of constrained resources and a steadily aging population on the delivery of health care to the veteran.
2. As our society ages, so does the veteran population when taken as a group. This group with their complex and extensive health care requirements, will require a wide variety of clinical services. The focus of these highly expanded services will give greater relative emphasis to the area of comprehensive geriatric care for chronic disabilities including acute episodic care, rehabilitative care, home care, and extended care. This change in focus for the VA hospital will create new and larger burdens on an already over-extended health care system. This is particularly true when considering the fact that the aged veteran patient, by virtue of the nature of their health care problems, is highly dependent upon nursing care. This fact will necessitate the addition of far greater numbers of nursing personnel resources with resultant increases in personnel costs.
3. Even today the veteran patient is coming to our hospitals in larger numbers than ever before, and he is more ill than ever before. As an individual patient, the veteran today is one who requires complex and sophisticated medical treatments for severe episodic outbreaks of chronic ailments. By the year 2000, 34 percent of all veterans will be aged 65 or over and in need of comprehensive medical, psycho-social or geriatric care.
4. In addition to the changes in age of veteran cohorts, this population is currently undergoing shifts in other demographic categories as well. Geographic distribution is affected in that veterans, and the population in general, are moving from the north and east to the sunbelt states. Also, as a percentage of the veteran population, women are increasing in number due to changes in social norms and career opportunities now provided by our armed forces. This fact in itself will necessitate ever greater expansion of medical services offered in order for the VA health care system to maintain a responsive posture.

5. Access to entitled health care services by the eligible veteran will be problematic in the future. First, there will be competition at the national level for increasingly scarce resources. This competition is not new, but it will become more intense as attempts to balance the federal budget and cut the costs of health care are made. Next, there will be competition for entry into the VA system by the health care recipients themselves. For instance, cuts in entitlement programs such as medicare, medicaid, and social security may cause patients who previously purchased their health care to access our system due to their own economic stringency.

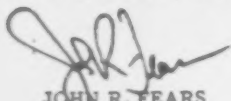
6. At the hospital level there will be, of course, competition for resources to support patient care activities. Many of our physical facilities are, themselves, aging and in need of repair, expansion, or replacement. Some geographic areas are over-bedded, while others do not have sufficient bed capacity or staffing to meet the demands of their patient base. Technologic sophistication is expected to increase with the advancement of new equipment such as lasers and nuclear magnetic resonance machines, and this sophisticated equipment will require additional resources to acquire it and operate it. Our experience with CAT scanner should not be repeated!

7. The VA has traditionally been at the cutting edge in developing new technology (prosthetics, artificial organs, specialty care research). To continue this tradition, a significant resource commitment will have to be made in terms of both money and manpower. Qualified staff, physicians, nurses, and other paraprofessionals or technicians will have to be recruited, trained, and retained in order to develop and operate this new technology. As their academic and clinical sophistication increases, so does their expectation in regard to compensation and attainment of professional goals.

8. In anticipation of changes in the educational needs of medical schools vis-a-vis the VA hospital as a training site, efforts should be taken to ensure that these affiliations remain open to change. In order to avoid tension in this area and to avoid the inability to train and recruit high quality specialty physicians, efforts should be taken to establish affiliation agreements which accommodate the educational needs of physicians as well as the clinical needs of VA hospitals.

9. Thus, to be successful in the delivery of quality health care services which meet the needs of our aging veteran population, thought will have to be given to the economic implications of providing this care. MEDIPP is the beginning step at planning on a level other than an institutional one, and this type of focus will become more crucial in the future. The VA's current resource dependence model, focusing on institutional resource acquisition, is antiquated and counter-productive for the system as a whole. Instead, a market-based planning process, focusing on the health care needs of the medical district or region, may ensure that patients' health care needs are

acknowledged and provided for. The time may be at hand when not every hospital can economically afford to be a "general hospital" equipped with all of the state-of-the-art technology necessary to provide this type of care. A more efficient and, perhaps, more effective health care delivery system may, in fact, be a district or regional level one which is composed of several VA specialty hospitals each one serving the populations' diverse medical needs. This system may be facilitated by using a community interactive model which merges the non-competitive, non-repetitive services offered in VA hospitals with the alternative delivery modalities such as satellite ambulatory care clinics, same-day surgery clinics, and home based health care services now found in the private sector.



JOHN R. FEARS
Director

cc: RD, Ann Arbor

Lakeside Medical Center

333 East Huron Street
Chicago IL 60611**Veterans
Administration**

August 16, 1983

In Reply Refer To: 535/00

Honorable Bob Edgar
Chairman, Subcommittee on
Hospitals and Health Care
House of Representatives
Washington, D. C. 20515

Dear Mr. Chairman:

You were kind enough to suggest that I write you my concerns about the future of the Department of Medicine and Surgery. This was done at the oversight hearings held in Chicago on July 7, 1983.

The VA must be viewed in the context of our current fiscal environment which is one of constraints on the present and future allocation of resources to the department. We are a mature and sophisticated agency which is composed of three parts: a major compensation and pension program, a national cemetery system, and the largest government operated multi-hospital health care delivery system in the free world. As the VA comes under scrutiny, I want to stress my belief that the Department of Medicine and Surgery is a great national resource which in the last four decades has provided great innovation in the delivery of health care. With appropriate support, the department will continue to provide such leadership -- on our way to greatness.

Let me be specific. We boast of giving patient care second to none, and I believe this to be true. We may expect that the demands for care will increase. The needs of the elderly veterans will grow as their number and ages increase. The one cohort which has not yet proportionately used the resources of the VA, the veterans of the Viet Nam era, may be expected to recognize DM&S as a major asset and to increase its utilization, which will further stress the system at its present level of funding. Coupling the increased demand with the need to continue to provide the high quality care, resources must increase.

The quality of the patient care we provide derives in part from the strength of our research over the decades. The Veterans Administration Department of Medicine and Surgery has been a front runner in innovations in care. We have been leaders in the development of long term care and rehabilitative medicine. As our consumers age, the demands for acute and ambulatory care have increased and this has heightened our awareness of the need to further enhance our research in new modalities of diagnosis and care. We have optimized certain kinds of treatment as a result of cooperative studies conducted through the entire VA system (e.g. the treatment of hypertension). Research in VA medical sciences has not only elucidated certain disease mechanisms, but has laid the ground work for further discoveries (radioimmunoassays). We have consistently been able to apply what we have learned and our discoveries have been heralded and adopted throughout the world.

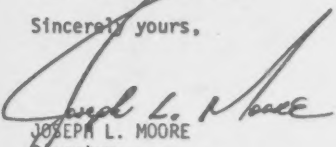
The role of DM&S in the development of clinical and research expertise cannot be over-estimated. Through our affiliations with medical schools and universities throughout the country, we have helped to train fully half of the physicians practicing medicine today. As a system which far pre-dates the multi-hospital systems which seem to be the wave of the future in the private sector, we have accumulated management and professional expertise.

Now we face a dilemma. We are expected to provide the highest level of care. Yet because of limitations of funding and proscribed methods of equipment acquisition and retention, we will not be able to replace critical technology as it becomes obsolete. Further, when equipment finally becomes available, our professional expertise will have diminished because we could not provide competitive compensation or attractive staff/patient ratios. Lastly, but clearly important, we must recognize the need for computer capability which is imperative for managing any contemporary system efficiently and wisely.

If we cannot stay abreast of the demands in delivery of levels of care we will not realize what I believe to be the unique promise of the system. This may be best understood in the context, once again, of fiscal constraint. The entire health industry is faced with the need to provide care of ever improving quality and provide it more efficiently. The relative cost effectiveness of care provided for all patients must be evaluated. What better opportunity can there be than to examine this in the context of a national system? For example, we are all aware of the dramatic changes in what is considered state-of-the-art medicine. One complicated technology has replaced another at a dizzying rate in the world of medicine in the last ten years, but the public all too frequently asked whether the latest "discoveries" will give us improved care in a cost effective manner. Indeed, I see the VA as a national "testing laboratory" which will provide the opportunity to make just such systematic evaluations.

I will end with a caveat. My imagination leads me to suggest a system which maximizes the possibilities of delivering excellent care on a nation-wide basis, of testing the effectiveness of different care options through the breadth of its programs, and of continuing outstanding research. All of this is based on stronger fiscal support. We must be able to compensate our professional and technical personnel competitively; we must be able to update our technological resources; we must maintain and continuously upgrade our enormous physical plant. With limited resources it is amazing how many accomplishments have been made, but many opportunities continue to be lost due to stringent limitation of funds.

Sincerely yours,


 JOSEPH L. MOORE
 Director

Medical Center
West Side

820 South Damen Avenue
P.O. Box 8195
Chicago IL 60680



**Veterans
Administration**

August 8, 1983

In Reply Refer To: 537/004

Regional Director (10BA4)
Department of Medicine & Surgery
VA Central Office
810 Vermont Avenue, N.W.
Washington, D.C. 20420

SUBJ: Congressional Hearings Response

1. As requested, the following comments are made in reference to the question proposed at the Congressional hearings, July 7-8, 1983 at the Hines VA Hospital: What should the future of the VA health care system be between now and the year 2000?

2. The Veterans Administration is currently going through a very difficult period and actions taken by the Congress and the agency in the next few years will dramatically impact on the Veterans Administration through the year 2000. For example, because of changes in the economy, Veterans are coming to the Veterans Administration in increasing numbers which exceed the capability of many Medical Centers to support. This situation is complicated by the open-ended character of the eligibility criteria.

3. To cope with this situation many Medical Centers are having to utilize non-recurring resources to meet current recurring needs. If this situation is not corrected by the infusion of additional funding or by tightening up eligibility criteria, equipment funding and non-recurring projects funding will erode in the short term and the quality of care will deteriorate in the medium to long term.

4. This situation will be further complicated if the agency attempts to realign funding within the system to meet burgeoning workloads in the sun-belt states because none of the other areas of the system are generously endowed with resources at the present time. Their resources have been depleted by the extent to which inflation has exceeded additional funding provided in the past several years. This is a problem which the Congress and the Administration must address as it is critical to the future of the Veterans Administration.

5. It is anticipated that significant changes will occur in a number of areas within the VA system between now and the year 2000. My thoughts regarding some of these major areas are as follows:

- a. General Direction. I expect that the VA will continue to strengthen its position in providing quality health care to the eligible veteran population. Since it is unlikely that a national health insurance program will be enacted in the foreseeable future, the viability and need for the VA system is renewed. Also, the aging veteran population and the shift toward outpatient care will have substantial impact on the VA system between now and the year 2000.

b. Aging veteran population. The number of veterans age 65 and over is expected to peak around 1990 at near 9,000,000. The impact of this change on the VA system will be substantial and continues to be one of the major issues which must be addressed through the MEDIPP process. This older population is expected to depend more and more on the VA system as they retire and lose employee health insurance benefits.

As support for other alternative means of health care are reduced, such as Medicare and Medicaid, eligible veterans currently utilizing the system will continue to come to the VA and probably increase their utilization rate.

Although the total number of veterans is expected to decrease, the needs of older patients tend to be greater and their recuperative time is longer.

The MEDIPP program is addressing the issue of the aging veteran population better than any system which was previously in place.

c. Workload. It is expected that the VA's overall workload will continue to increase, particularly in the outpatient area. Although there will be fewer veterans, it is assumed that their utilization of VA facilities will be greater. Further, changes in the economy and reduction of alternative means of financing health care will cause greater numbers of Veterans to seek care in V.A. facilities.

Escalating demand for health care make it essential that the V.A. have computer systems which improve ability to predict workload demand. It is essential that comprehensive data be provided to the Congress so that either adequate funding can be provided to meet the workload demand or that improved mechanisms be provided through legislation to permit the V.A. to control workloads.

d. Affiliations. We will continue to emphasize and strengthen the medical school affiliations, as well as the other spectrum of affiliations the VA has.

We should continue to emphasize to the universities that the contributions made by the VA are significant, and that their reliance on us is greater now than it has ever been.

e. Research. Research has been a strength of the VA for a number of years, and it is essential that it continue to be an avenue which supports our recruitment of highly qualified staff.

f. Technology. The technological revolution will continue and will result in major changes particularly in the area of automated data processing and diagnostic equipment. As a result of computerization, information systems will be vastly improved. The VA is considerably behind the private sector in the area of computerization, and significant emphasis and resources need to be directed toward this area.

Because of its size and demonstrated technological expertise, the Veterans Administration should assume a leadership role in the development and testing of new technology. This should be accomplished in collaboration with the private sector and a mechanism should be developed to provide an economic incentive or reward to the Veterans Administration such as reduced costs for equipment developed and/or tested totally or partially by the Veterans Administration.

g. VA-Military Affiliation. It is expected that the VA system and the military health care system will develop increasingly closer ties. The Veterans Administration will function as the primary back-up to the military hospital system. Contractual arrangements will be increasingly developed for the sharing of scarce medical and other resources and services.

h. Physical Facilities and Equipment. The Veterans Administration will need to continue a comprehensive program to renovate, improve and replace Medical Centers. Likewise, it will be essential that medical equipment be replaced as it becomes aged or obsolete and that adequate funding be provided to permit the Veterans Administration to be at the forefront of technological advances in the health care field. There will be a significant need for an increase in outpatient facilities throughout the VA system. Improving the accessibility to VA care through the development of additional satellite clinics will also be emphasized.

i. Clientele Served. It is expected that service-connected Veterans and indigent non-service connected veterans will continue to be the primary users of VA facilities. The main difference may be that the criteria defining indigents' eligibility may change.

The open-ended definition of eligibility is a point of concern for the present and the future. Being responsible for taking care of non-service connected veterans to the extent of our resources places the medical centers in an extremely difficult position during economic times such as that currently being experienced. Patients often find that other sources of care, such as County and City Hospitals and outpatient facilities are no longer available to them, which will increase the demand on the VA system. At the same time, resources are less available than in the past to take care of this increased workload.

The result is that the V.A. must either turn away significant numbers of non-emergency but economically disadvantaged Veterans and alienate that portion of the agency constituency or provide care to Veterans in excess of the resource capability to support and be party to a significant deterioration in the quality of care provided.

For this reason, it is increasing important that we have adequate staff and resources to take care of all non-service connected veterans who can not afford care elsewhere. Otherwise, there will need to be additional strength placed behind the poverty oath, so that the medical centers can maintain a reasonably sized workload which can be supported by the resources it has available.

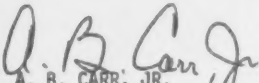
j. Resources. Burgeoning workloads and shrinking resources constitute a serious problem for the VA system. Without additional resources, the quality of the care we can provide will suffer.

There is a need to correct the maldistribution of resources which presently exists in the system. However, funding should not be taken from those centers who simply have proportionately more than others, if their level of funding is not adequate to meet the needs of their patient population. It will possibly be necessary to input more resources into the system as a whole.

k. Public Relations. The VA has realized the importance of having good public relations and of publicizing our track record and the quality of care we are providing. At the present time very little, if any, funding is provided for such a program. It is essential that the Congress authorize adequate funding for this extremely important program.

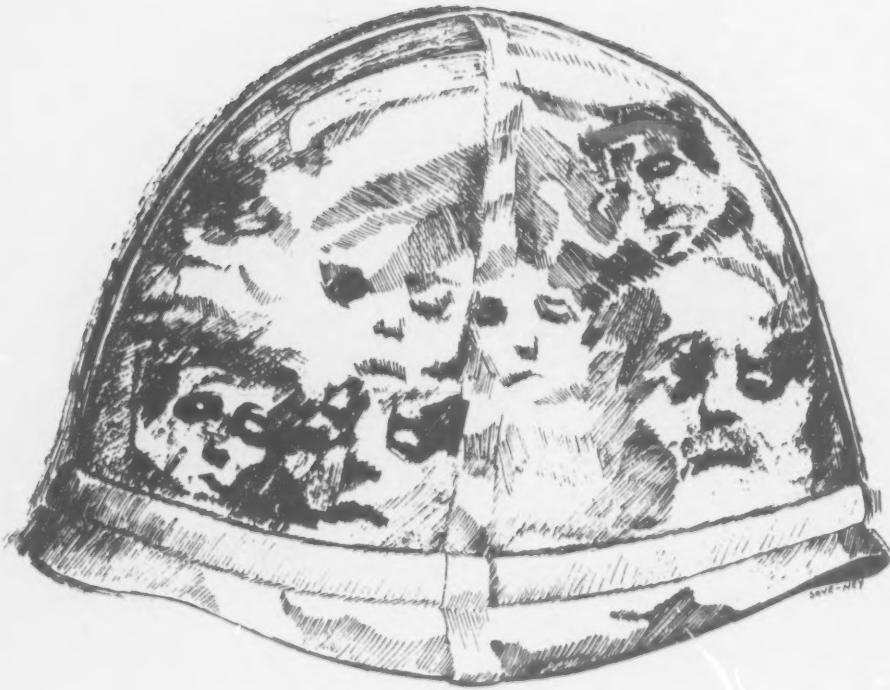
l. Service Organizations. There needs to be an increasingly strong bond between the VA and the Service Organizations.

m. Eligibility. There is a need for a re-evaluation of the eligibility of those who are service-connected for a combat injury vs. those who are service-connected for a non-combat injury. There is question of the appropriateness of a service-connected veteran who is being seen for a minor illness taking precedence over a more seriously ill non-service connected veteran. Perhaps a more equitable breakdown would be to divide eligibility into two major categories: 1) veterans with service-connected combat injuries or illness and 2) service-connected veterans with non-combat injuries or illness and veterans with non-service connected injuries or illness who cannot afford health care elsewhere.


A. B. CARR, JR.
Medical Center Director

cc: John Fears
District Director

TEENAGE WARRIORS



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I'd like to thank you for allowing me to come here today to try to tell you my story. One thing Congressman Evans didn't tell you about me is that I'm a old-fashioned, flag-waving American citizen who still can't make it all the way through the "National Anthem" without choking up and I still get goose pimples when I see the flag passing in a parade. I come before you today to appeal to you to use the powers of your office and the prestige you have in the community to help me in my efforts to finally bring our Vietnam veterans "home". When I refer to "my story", it is the story of thousands of women like me whose husbands, sons and fathers have only partially completed their return from Vietnam back to "the world" because in their memories, through their dreams and buried in their subconscious minds they are still living the horrors of a war which was fought by a force of men whose average age was barely 20 years.

My Personal Introduction to Stress

In 1971, I married a returning Vietnam vet. I had been married before and had three children. We moved to David's next duty station, Fort Carson, Colorado and set out to start new lives. We did so with all the hopes and dreams that can be shared by a newly-wed couple and a ready-made family.

By the time we arrived in Colorado Springs and settled into our temporary off-post housing, it was nearly Christmas, and David was filled with anticipation about his first shopping trip for Christmas presents for me and the kids. He insisted on shopping without me, but since he didn't drive, he asked his friend Roger to drive him into town so he could pick out all of the surprises he wanted us to enjoy Christmas Day.

As David was carefully going over the selection of bargains for the Holiday Season, he suddenly gripped his chest, looked at Roger and said, "Christ, man! I been shot. Get me out of here." Less than an hour later, Roger had him back at our apartment and the ambulance attendants from the post were trying to calm David. He had pulled his pocket knife and was standing on top of an end

table next to our bed, slicing through the air with the knife and screaming at the attendants in Vietnamese. After days of extensive tests, X-Rays and counseling, the doctors told us that David had a piece of shrapnel in his lung. The metal was being rejected by his body and the body was going through the normal function of eliminating the foreign material. In doing so, it was tearing at the wall of the lung, causing such severe pain that David believed he had been shot. The doctor explained to us that the pain of the lung being ripped was so severe that the body could not withstand it...therefore, the mind took over. David's mind permitted him to travel back in time to a point prior to his being hit by the shrapnel. He could believe he had not been wounded, therefore, since there had been no wound, there could be no pain.

"Metaphysical." A new word to add to my vocabulary.

Several weeks later, I awoke one night to find the other half of our bed empty. After checking all the other rooms in our small apartment, I slowly opened the door to the room shared by my two children, Lisa, age 8 and Brian, 2½. The light from the hallway seemed to zoom in on a shiny object lying across my little girl's neck. As I opened the door further, I saw David, on his knees next to the bed. The shiny object was a bayonet. David looked at me and smiled, and whispered, "Shh. I got me a 'sloop'." I froze. I remember praying for guidance, and I even remember wondering how long it takes for a prayer to reach God and for Him to send an answer. I felt all the strength draining from my body, my legs went weak and I dropped to my knees. David motioned me to come to him with the wave of his arm. I crawled over to the bed, wondering if there might be any way I could get the bayonet without injuring my sleeping daughter.

"Here," David whispered, handing me the bayonet, "I'm gonna get the lieutenant. Keep an eye on him."

I took the weapon and watched my husband crawl on his hands and knees out of the bedroom and up the hall. I sat on the floor and wept. My little boy, who had been asleep on the top bunk

leaned his head over the side of the bed and said, "Mommy, why are you going to hurt Lisa?"

David had crawled on into bed and was sleeping soundly. I spent the rest of the night sitting on the living room couch so I could have clear view of both of the bedrooms. I sat with the bayonet laying on my lap. As the morning sun started filling the living room, I looked at the blade of the weapon. Carved into it were the words, "Yea, though I walk through the valley of the shadow of death, I will fear no evil - for I am the meanest son-of-a-bitch in the valley."

"If I Tell You What I Did in 'Nam, You'll Hate Me."

David would sit with buddies at Fort Carson and tell light, funny stories about their experiences in Vietnam. He told me many times during our marriage that he would never talk about some of the things that happened, and there was one incident he would never be able to share with me. He said, "You would stop loving me. If I tell you what I did in 'Nam, you'll hate me and I can't lose you."

Four years of marriage would pass before I would be told what prompted the incident in my children's bedroom. Only after he had left for Germany and could relate it in the distant form of a letter would I learn what David was re-living the night he held the blade of his bayonet against my daughter's throat.

"Ellis and me caught this little kid trying to steal food from our hootch. I had him by the neck and had my knife at his throat before Ellis yelled at me that it was just a kid. We stripped him naked to be sure he wasn't booby trapped. Some of the guys wanted to waste him because kids were killers there too. But I didn't think this kid was. They told me I could take him in but I would be responsible. The kid had probably been on his own most of his life, living off the land and one thing for sure he never learned how to do was use the latrine. One day the Sarg stepped in a pile of his crap and took Tye and rubbed his nose in it like a dog. It took weeks, but I taught the kid how to use

the can. He worked cleaning the hootch for me and Ellis and we gave him food and clothes. The guys all teased me because about the only words he could say in English were, "like Davi-sun." I carved a rifle for him. Nights he would sleep on the floor next to my mat. One night he crawled out of the hootch to go to the bathroom. The next thing we knew, we heard a shot. One of the guys was using the latrine and when he came out he saw Tye but didn't know it was him. He called out for identification and Tye answered in Vietnamese and the asshole shot him. He said he wouldn't have shot if it hadn't been for that gun. I killed that kid just as sure as if I had pulled the trigger myself."

I never saw David again. When he returned from his tour in Germany, he filed for divorce. He truly believed that once I knew about that little boy, I could never love him again.

I could not come before you today and tell you about David without at least making an effort to find out how he is today, or even if he is still alive. I made a concerted effort to find him or someone who could fill me in. Last week, I spoke (for the first time ever) to a man who for six years was my father-in-law. He told me that in the years since, David has suffered severe bouts with alcoholism, stress and a total inability to make a lasting commitment to a woman. He will never again allow himself to become close enough to another woman that he would be prompted again to share his memories of Tye - the little boy whose life David shared and whose death David believed he was responsible for.

Delayed Stress. Post-Traumatic Stress Disorder. Flashbacks. Blackouts. It's taken me nearly ten years to even begin to understand these terms. Had I known their meaning and their consequences in 1971, one of two things would have happened. I would still be married to David today, trying to help him overcome these problems, or I would have run like hell at the first hint of a problem.

Instant Replay + Five Years

After my divorce from David I remained single for five years. I didn't think much about him and I fell into that segment of society that was determined to put Vietnam into the history books, mark it "the past" and forget it.

In August of 1981, I remarried. He had been a "lifer", retired after 23 years of military service. We were living in St. Paul, Minnesota and within weeks of our marriage, Chris left St. Paul to take a job in Rock Island, Illinois. He would return to Minnesota on weekends, then back to Illinois during the week. I had a good job, owned a home in Minnesota and until we were sure his new position would work, we decided not to uproot and move.

He shared with me the horror he had suffered with flashbacks. He described how once he was driving down the freeway and suddenly the pavement turned to a gravel road, the maple trees turned to palm trees and the noise breakers along the freeway became the picket booby traps set by the Viet Cong. A passing state trooper pulled over to help him and recognized the symptoms of a flashback.

At the time of our marriage, Chris assured me that his problems had been solved with extensive therapy at the V.A. hospital in Minneapolis, in addition to the fact that a doctor in private practice had de-activated his thyroid in an effort to "control" his behavior.

With winter approaching, Chris and I decided if the weather was the least bit questionable, he should not attempt the 350 mile drive from Rock Island to Saint Paul. One particular weekend the weather was terrible. I didn't expect him home. I was in the TV room in the basement when I heard a crash on the floor upstairs and ran up to see what had happened. I found my husband lying face down on the dining room floor. I tried to talk to him but he shoved me away and crawled to the stairs which led to our bedroom. There were 14 stairs and he made it to the 12th one, then slid on his belly to the bottom. The noise awoke my daughter who came from her room to see what was happening. Chris was

lying at the bottom of the steps, crying and saying over and over, "Get up, Chris. You have to get up. If you don't get up you'll die. You did it before and you can do it again."

I told Lisa to come down and sit on him to prevent him from crawling back up the stairs and I called the paramedics. They checked him over, determined he was in no immediate danger and helped me settle him on the couch. The next morning, as I walked through the living room, he opened his eyes, looked around and said, "How did I get here?" He had driven 350 miles in a blinding snow storm and had no recollection of the trip.

A NEW EXPERIENCE-DOMESTIC VIOLENCE

Several weeks later he came home for one of his weekend visits. He was sullen and moody all day. I left him alone. I decided to watch television until I knew he was asleep.

Suddenly the door burst open and he stood there. His fists were clenched and pressed tightly against his sides. His eyes were black and he was breathing heavily...seething. He just stood there looking at me. Then he said, "You fucking gook! You killed my people!"

Before I could move, he jumped on my chest and started choking me, all the while jumping up and down on my chest. I felt faint, then nothing. I had lost consciousness. When I came to, he was still sitting on my chest, but had my tongue pulled out of my mouth and he was burning it with his cigarette.

He kept saying, "I'll teach you to talk, gook!"

I was crying and he pulled back and looked at me in what I could only describe as amazement. Then he began to cry. He was shaking and sobbing.

I said, "It's OK, it'll be alright."

He got off of me and ran out of the house. It was days later before he called me. He remembered nothing of the incident and only knew that "something terrible" had happened.

I talked him into going back to the V.A. hospital for counseling. He said he would if I would go with him. I accompanied

him once to a therapy session during which the doctor and I got acquainted. She said she would see us together sometimes, separately other times. She warned us that we should be ready for a "long haul".

Our first visit was on March 5, 1982.

I saw Chris changing. But not for the better. I felt like I was living with a walking time bomb and I lived in fear of what would light the fuse. I considered telling him not to come home. I didn't because I could not anticipate what his reaction would be. I didn't know if staying with him was worse than being without him.

Just before midnight on March 23, the fuse was lit and for the next 16 hours I would experience the greatest horror of my life...the horror of watching years of backed up resentment, hatred, fear anger and even revenge suddenly unleashed. With the exception of four hours that I sat curled up hiding in a closet that Chris didn't know about, I would spend that day discovering first hand the meaning of physical pain.

He had removed the phone from the hook in the basement and locked the door so I couldn't call for help. At 3:30 I crawled out of the closet and heard him on the phone. I waited until I heard him hang up then called for help. At 3:45 that afternoon the St. Paul police removed him from my home, warning him to head his car in the direction of Illinois and not look back.

I added another word to my vocabulary that day. Adult Maltreatment. That's what they called it at Ramsey County Hospital. I experienced the humiliation of having to have a tetanus shot because at one point he bit me in the foot. I had to have my shoulder-length hair cut because he had ripped patches of it from my skull. But most of all, I had to watch my 18 year old daughter going through all of the pain with me.

Upon my return home from the hospital, I called the psychologist at the V.A. and told her what happened. Chris had already called her.

I said, "Doctor, this is getting worse...he's going to kill

somebody."

She said, "Yes, I agree."

I said, "Then what can we do?"

He response was clinical and cold. "The only thing you can do is be sure it's not you."

New Hope

Weeks passed in silence. Then, the first week in May, Chris called me. His voice was calm. He sounded controlled and - - -- peaceful.

He told me about a group he had joined - the Quad Cities Vietnam Vets. He told me that it had made such a difference in his life because for the first time he realized he was not alone in his suffering. There were others, many others, who felt his pain, who had tried to shut it out, turn it off - forget. He spoke of a comradeship, a brotherhood that he never knew existed. He said, "Lori, this is my answer."

We began working at getting back together. I visited Rock Island and met the other members of the group. I knew immediately why Chris felt so comfortable with them - just as comfortable as I felt with their wives. I truly believed we could start over this time on the right foot...not ignoring the problem, but learning to live and deal with it. I knew we could never put Vietnam in our mental history books, but I had hope that we could learn to control it rather than having it control us.

I made the decision to move to Illinois and be a full-time wife and support my husband on a full-time basis.

Trends

The "experts" in the field of Post-Traumatic Stress Disorder will tell you that the effects of PTSD will peak by 1985 and that if something is not done to reverse the trend, the patterns will become irreversible and permanent.

The group worked for Chris. But only to a point. When he reached the point where he once again needed professional gui-

dance to learn to channel what the group was teaching him, his distrust for the V.A. prohibited him from accepting the helping hand that had been extended by Dr. Warren Edwards at the V.A. hospital in Iowa City.

I again felt that the fuse was ready to be lit and I lived in constant fear. I never knew when he came home at night if he was going to kiss my on the lips or punch me in the mouth.

I was losing control of my own life and experiencing chest pains which are the result of a re-occurring heart condition. He began to threaten to leave me if I didn't "stay in line". After several weeks, I was too tired to argue and told him to go.

I simply couldn't take another beating. On October 27, I sat in a courtroom and listened to the judge tell me that my marriage was dissolved.

I set out at that point to leave no stone unturned to understand Delayed Stress, and if at all possible to try to help someone else through what we had failed to accomplish.

I heard that a psychologist had been given a contract to work with the vets on a referral basis, but the money was being held back. I wrote to the doctor, Kirk Witherspoon, and asked what I might do to help speed up the process. The vets couldn't remain "on hold". The need was now. We had lunch together and I believe I found out what happened with Chris at that point. As I sat and picked away at my Rueben sandwich, Dr. Witherspoon said, "The group is good, but it's not enough. As it stands right now, emotions are poured out, wounds are opened, guards are dropped, but without professional help, these guys don't know where to go with what they are feeling." He was exactly right. When an immediate need is felt, a trip to Iowa City can take forever.

I recognized Chris in what he was saying. He had opened up, poured his guts out to these guys who understood, laid his feelings on the table, but had no professional help to sort it out and put it all back in the right place.

ALONE AGAIN - NATURALLY

With the other kids grown and in Minnesota, it was me and Brian who is now 15. Chris had quit the group, saying he didn't need them any more, that he would make it on his own. I missed the warmth I felt with the group because it was a place I could go and pour my heart out without having to apologize because every person in the room could relate to my pain. I went to a couple of meetings, but felt that the group didn't trust me. One of the members later told me that he wasn't sure of my motives, that I might be coming in to encourage other women to divorce their husbands. Also, I think they saw Chris and me as an indication that the group is not always successful.

I had been hired as Executive Secretary-Office Manager at Prairie State Legal Services in Rock Island. One of the priorities of our office is to represent clients who desire to petition the court for an Order of Protection. Too many of the women calling our office were wives of Vietnam veterans. When I brought this to the attention of our administration office in Rockford, it was suggested I prepare material for possible use as a brochure.

I had just completed the first draft when our office was visited by a woman who had come to speak to our attorneys about a new program that she was coordinating. It involved channeling women who had been housewives most of their lives into the work force. These are women who probably have never worked, have no specific marketable skills but by reason of divorce or death of their spouse, suddenly find themselves the family bread winners. I volunteered my skills and time to her and to the program. She asked me what my special interests were and I told her about the brochure I was preparing. There was a look of fearful recognition on her face as she asked for a copy. Two hours later she phoned me at my office, crying so hard she could hardly talk. She said, "You did a profile of my ex-husband." She told me they had been married for 12 years and she never suspected there was any kind of problem with Jim. He had been in Vietnam, but never *talked about it.*

They went to see the movie, "The Deer Hunter." Jim was silent as he started driving home, then pulled the car to the side of the road and laid his head on the steering wheel and cried. She drove the rest of the way home, and when they arrived at the house, Jim packed his suitcase and left without any explanation.

She said, "For two years I have wondered what I did wrong. I have hurt over it endlessly. I never understood...until now...until I read what you wrote. I even realize now why the slides he took had no people in them." I acknowledged that for the slides to have people would have been to humanize a situation that he may have mentally been able to dehumanize.

Shortly after Christmas she called to thank me. She said Jim called her on Christmas Eve. "I have never heard him so depressed. He asked for a box that he said he left in the basement and asked if he could come over and pick it up. Six months ago I would have given it to him without question. Now I am on guard. I looked in the box and it contained his service revolver and ammunition. I told him I could not find it. My gut feeling is that the day I give him the gun he will use it on himself. I will never give him the gun."

DISPROPORTIONATE FIGURES AND FRIENDLY FIRE

There are 9,110,000 Vietnam veterans in the United States. This is a figure equal to the population of the city of New York. It also represents 4% of the total population of the United States. In the East Moline correctional facility, 50% of the inmates are Vietnam veterans.

I'd like to tell you about one of them. He was 18 when he graduated and undecided about where to go to college, what to study or how he wanted to live the rest of his life. His father was very angry when he announced that he had enlisted in the Army and was going to Vietnam. His father was even more angry when his son chose to join the ranks of the "grunts" rather than follow in the older man's footsteps and become an officer.

"We were on a run. We felt good because we had knocked

Charlie right out of his boots. None of us expected it to go as smooth as it did. We were just sitting there, feeling so damn smug about it. Then we heard the choppers and the last thing I remember thinking was that we would have a hot supper. The birds came in and we stood there waiting to be picked up. We heard the rattle of the gun fire and scattered. I couldn't believe they were firing on us. I got behind this big goddamn tree and stood there watching the guys gettin' picked off and I ran out and started waving my arms at the choppers. My arm felt hot and wet and I looked at it. I had taken a hit and didn't even know it."

Before it was over, he had taken not one hit, but six. The physical wounds were easy to heal compared to the psychological ones. The decision was made to return him to the states for extensive treatment. He arrived at the airport, back home, on May 5, 1970 - the day after the incident at Kent State. His plane was greeted by demonstrators carrying banners filled with angry hate slogans and voices shouting, "Hell no...we won't go!" One of the demonstrators yelled, "Bombs away," as he tossed a pop bottle at the men entering the terminal. The bottle found its mark, making the seventh wound. But it did more than that. It cut the thin thread that held this man's sanity in tact. The shattering glass of the pop bottle sliced that thread.

He never did attend college. He never became a doctor or a lawyer. He never married and had children. He has spent the last 10 years in and out of prisons with little hope that the anger he feels can be controlled to the extent that he will not lash out at whomever or whatever is handy.

STUFFED FEELINGS COME OUT SIDEWAYS

At the onset of my testimony, I told you how the shrapnel in my husband's lung worked its way out. The mind should be allowed to function in the same way. It too rejects foreign "material" or ideas. If something is distasteful to me, I say, "I don't want to think about this." "I am going to put this out of my mind."

When the returning Vietnam veterans were returned to the United States they were greeted with resentment and blamed for the war. No thought was given to the society that sent them there. It was a personal blame that each of them had to learn to carry and try to accept.

It didn't take any of them long to realize that the protected class they had left behind just didn't want to hear about the war. It was all stuffed inside and allowed to fester and grow for ten years.

CRY BABIES

There are even those uneducated, quick to judge individuals who consider the Vietnam veterans "cry babies" because they didn't recover like the World War I or II vets, or the Korean vets.

In both World War the average number of combatants returned home prior to the end of their tour for psychological counseling was 230 out of every 1,000 sent overseas. In the Korean Conflict with the improved system of counseling in the field, the number decreased to sixty out of every 1,000. In Vietnam however, a new experiment was tried. It was called DEROS. In Vietnam, the number of combatants returned to the United States prior to their DEROS for psychological reasons dropped to 12 out of every 1,000. It became evident that the DEROS played a major role in the ability of the combatants to "keep it together" because they knew exactly when they would be returned stateside if they were not wounded. When I visit the dentist, I mentally calculate the longest possible time it might take and "psyc" myself into believing that I can handle any pain he might inflict if I know it will take one hour. In Vietnam it took one year and the men psyched themselves into believing they could take it for the 12 months, then 8 months, three months, two weeks and home.

Another important factor in comparison, for the benefit of those who have labeled Vietnam veterans "cry babies" is the fact that the average age of the World War I and II combatant was 25. In Korea, the number dropped to 22 and in Vietnam it was 19. We

sent younger men into battle-potential situations for longer periods of time.

I recently read where one of our political figures referred to Vietnam as a "National hang-over." That's pretty accurate in many respects. As far as the vet is concerned it's accurate in a respect that was not implied. The only understanding a person gets when he or she is suffering from a hang-over is from another person suffering from a hang-over.

IT'S TIME TO END THE WAR AND BRING THE VETS HOME

The 1983 World Almanac summarizes the period of 1970 to 1979 as "Disillusionment". It says, in part, "U.S. defeat in Indochina (evacuation April '75), revelations of Central Intelligence Agency misdeeds and the Watergate scandals reduced faith in U.S. moral and material capacity to influence world affairs."

We have for years, and we continue to lump Vietnam with the scandals that our country suffered. Every time we do this, we slap these warriors down again.

The war was not lost because of anything they did or did not do. It was never intended that there would be a winning side. There was no military objective. Other wars were glorified with movies called "Pork Chop Hill", "The Longest Day", etc. These conflicts had military objectives. Vietnam became a war of body counts. The only measurable factor of progress was casualties.

If this country is to ever again live in peaceful brotherhood, we must start with the Vietnam veterans. We must stop making promises to him that we cannot keep. We must stop dangling bits and pieces in front of him and do something solid and concrete to help him find the peace from within that we have denied him for the past 15 years.

Until and unless we do all in our effort to bring these Teenage Warriors the rest of the way home, our country will continue to live in the kind of shame that we have allowed to exist.

I thank you for sitting through this lengthy testimony and I am not ashamed to beg you, on behalf of my brothers to do all in your power to give them the long-over due help they need.


Lori Johnson

Post Script: As an attachment to this lengthy testimony, I would like to include that portion of the Congressional Record which contained what began as a job assignment. It is my goal to update the paper and expand on it, incorporating experiences that others have shared with me since reading it.

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tee simply felt that legislative action was required to provide long-term continuity and stability to a much needed new national advisory committee.

Finally, Mr. Speaker, the House Veterans' Affairs Committee has had a long-standing concern about excessing VA property that might well be needed by VA in the future or sometimes needed at the very time excessing is proposed. H.R. 2920 speaks to the issue and seeks to assure that VA holdings, particularly its medical property, will not be excessed unless it is entirely appropriate and necessary, and recommended by those who have expertise in VA programs and its future needs.

Mr. Speaker, this is a good bill. It has received extensive study. Its provisions are sound. I congratulate all of those on our committee who have worked on it, and I urge its passage by the House.

□ 1230

Mr. Speaker, I reserve the balance of my time.

Mr. MONTGOMERY. Mr. Speaker, I yield 5 minutes to the distinguished gentleman from Illinois, Mr. LANE EVANS.

(Mr. EVANS of Illinois asked and was given permission to revise and extend his remarks.)

Mr. EVANS of Illinois. Mr. Speaker, each year billions of dollars are taken from State and Federal coffers to provide for the operation of hospitals and health-care facilities. We place considerable emphasis upon the upkeep of health-care programs for the elderly, the disadvantaged, and veterans. And we spend millions of dollars each year to maintain our public mental health facilities.

And yet we now face the possible elimination of one of the most successful and well-designed programs ever implemented in the mental health field—the VA's Vietnam veterans' readjustment counseling program, better known as the vet center program. This worthwhile effort was started only 4 years ago in an effort to provide veterans of the Vietnam era a successful reintegration into American society.

I have introduced legislation to extend the vet center program for a period of 3 years. I believe that it is absolutely necessary that our colleagues realize the danger of not continuing its important function.

Many of these young men and women who served in Vietnam encountered a war which still vividly lives in their minds today.

Flashbacks, nightmares, and psychological trauma are an everyday occurrence for many. And these problems were compounded by the negative feedback they received from an unappreciative American public. In many cases, what resulted were psychological regressions of the type found in posttraumatic stress disorder.

The vet center program was designed specifically to help these indi-

viduals come to grips with their unique problems. And no other segment of the Veterans' Administration has the capacity to address the readjustment problems of those. An extension on the program's life will allow the thousands of veterans still suffering to benefit from this needed service.

Mr. Speaker, as an original sponsor of H.R. 2323, which has been included within the VA health-care bill, H.R. 2920, I urge my colleagues to give their full support to this measure.

I would also commend to my colleagues the following essay by Ms. Lori Johnson of Moline, Ill., which graphically describes her personal encounters with posttraumatic stress disorder:

DOMESTIC VIOLENCE "BATTERED WIFE" . . .
OR VICTIM OF VIETNAM?

We will sit and laugh at movies and comics depicting cavemen dragging their mates around by the hair or keeping them in line with the use of clubs, but the truth of the matter is, domestic violence is painful. If you are the victim of domestic violence, there is, as you know, nothing funny about it.

Use of force (physical or psychological) is nothing new. It's been used for centuries to exercise control of one human over another—enemies, friends, wives, girlfriends, children and even parents. In many instances, the acts are committed without the person being able to account for why they acted or reacted in the manner which they did—a manner oftentimes resulting in physical harm to the person who, in many instances, is someone dearly loved.

Perhaps even more frightening than not being able to account for why, is the realization that sometimes there may even be no recollection of the act of violence itself.

"I was sitting in the TV room and suddenly the door burst open and there stood my husband. His arms were held tight against his body, his fists were clenched and he was breathing heavily—almost gasping.

"He stood there looking at me, and said, 'you f— Gook! You killed my people.'

"Before I could move, he jumped on my chest and started choking me. I felt faint; then nothing. I had lost consciousness. When I came to, he was still sitting on my chest, but had my tongue pulled out of my mouth and he was burning it with his cigarette.

"He kept saying, 'I'll teach you to talk, Ewok!'

"He began crying. Sobbing. Like a little boy. He moved back and looked at me, like I was a stranger. Watching him cry, all I could say was, 'It's OK, it'll be alright.' He got up and ran out of the house. It was days later before I saw or talked to him. He remembered nothing about the incident."

The above account is a true incident, described by the wife of a Vietnam veteran, who, during a flashback actually believed that his wife was a Viet Cong infiltrator who was responsible for the deaths of eight of his men.

Flashbacks. Blackouts. Words common to the vocabulary of Vietnam veterans and their families who are seeking help for a new phrase that everyone should become familiar with and add to their vocabulary: "Delayed stress syndrome."

There are, of course, those who will call it a cop-out. Sadly, there are some veterans who will use it as a cop-out, but it's like a cancer, which if left unattended, will not go away.

Some skeptics will even say it's a new affliction of the weak, and those unable to cope in today's society. The data surfacing will contradict this theory—that it was the stronger, the more controlled who are now (ten years later) finding the memories and the terror creeping back into their lives at unguarded moments. A very popular television series today depicts its main character, a rough and tough private eye frequently experiencing flashbacks and making reference to "stress." Surely, it is not an affliction of the weak nor those unable to cope with everyday pressures. It doesn't have to take the form of flashbacks or blackouts. There are many equally obvious side-effects. Nightmares (sometimes not even remembered by the vet—but often vivid enough to his bed partner); unexplained and unprovoked fits of rage; severe depression; and frequent mood swings. The high incidence of alcoholism, drug abuse and crime among Vietnam vets is criticized by the masses, but, like domestic violence, understood by few—until now. We now see real attempts being made to understand, cope with and resolve. But before the problem itself can be understood, the reasons which created it must be understood.

Volumes have been, and still are, being written concerning the causes for delayed stress syndrome. One of the major factors emerging is the undeniable fact that Vietnam was different than any military involvement this country had ever seen. It was fought different, its popularity was different and it was reported different by the news media. Subsequently, we, as Mr. and Mrs. John Q. Public, reacted in our "American" way and treated our returning vets different.

In World Wars I and II, the average age of the fighting force was 25; in Korea it was 22; in Vietnam, it was 19. Tours differed in length. We sent younger men into battle potential situations for longer periods of time. When the tour was completed, he didn't have six weeks on a ship with his buddies to make the physical and mental transition from soldier to civilian. What our Vietnam vet had was thirty-six hours from jungle to living room—cold turkey.

From the understanding fellowship of his "brothers" in Nam to families and friends who did not understand and all too often did not approve of their son's involvement in the war they witnessed on their television sets every night with their dinner. The folks at home flew the flag in honor of their son who was "off in the war", but they could never accept the fact that their son and/or brother actually took part in the kind of warfare that they were seeing on the tube. "Did they really cut off the ears to keep body counts—well, you didn't, did you?"

The C.O. decided I needed time state-side to get my shit together. When I got home and felt safe I started to relax. The folks kept saying, "You're different. What's bothering you?" I started to talk and couldn't quit. They listened to me. Mom looked at me like I was some sick stranger who had invaded her kitchen. Dad just looked sick. Then they pleaded with me not to go back. I was so sick of killing and massacre. I stayed home. I knew they'd catch me and take me out. They caught me and threw me out. Every day I look at my 'bad paper' and sometimes I resent my folks for talking me into staying home. But I couldn't go back. I couldn't kill any more babies."

Most returning vets found they could not share their combat experiences with the folks at home. In some more select and publicized instances, we felt the need to whitewash the unacceptable activities through

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the courts and we used people like LA. Calley to pacify our guilt.

Most of the vets simply lied to their families. Then they started lying to themselves. That works—but not for long.

Stuffed feelings come out side-ways. You can take your anger and pain, your frustration, bad memories and hurt and stuff them all way into a deep corner of your subconscious. But, they will come out. When your guard is down; when you least expect it. When you are least able to cope with it, there it is.

"I'd been home from Nam for eight years and hadn't even thought about it that much. Then my son and I made our plans to go on our first-ever deer hunt. We were both excited. The weather was unseasonably warm that day. I remember going into the woods and thinking how beautiful it was. Then it wasn't beautiful anymore. The first gun shot set me off and I was back in the jungle. My son wasn't twelve years old any more. Now he was my buddy. The next thing I remember is him leaning over me crying, 'Daddy, don't you remember me?' Later, in one of the group meetings, my son told how I started talking out of my head about the Cong being just over that hill. The 'Cong' that I described was another party of hunters. All I can remember is that before we left I felt so good—so safe."

Fortunately, the majority of the vets returning from Vietnam made successful transitions back into the mainstream of the populace. They were able to go back to school, get good jobs, have families. Put the war behind them.

Even some of them have found the war creeping back into their lives in the form of birth defects in their children. We armed our men and boys with the most modern tool of chemical warfare—agent orange, and by doing so, turned our own children and children for generations to come into casualties of the Vietnam war. This realization and the fear felt by the vets who are now fathers, is a contributing factor to delayed stress syndrome.

The suicide rate among Vietnam vets is staggering.

Again, hitting closer to home (literally) is the increasing incidence of domestic violence.

"I want to be close to my wife and kids, but something inside me keeps me from getting close.

"Even in a room filled with friendly people, I make sure I find a chair against the wall. Need to 'cover my back."

"Sometimes, like maybe I'm walkin' down the street and I see this kid walking toward me and I wonder if he's carrying a bomb to blow my — away—like happened to Bill."

Vietnam veterans, with and without the help of informed professionals, have begun working to control the effects of delayed stress. With the help of professionals, they can be found in group therapy sessions. Without the help of professionals, they can be found in informal rap sessions, group meetings, etc. call it what you will. They find the comradeship that they have been lacking for over ten years and in being able to openly discuss their fears, their desires, and even the things they did that have been pushed back into their minds, they are better able to deal with delayed stress.

Certainly, no one would claim that every man who commits domestic violence is suffering from delayed stress. That assumption would be as foolish as saying every Vietnam veteran beats his wife and kids. But, in households which have had occurrences of domestic violence, and there is a Vietnam veteran involved, it certainly must be worth exploring the possible connection.

"When my husband would come home from work, I never knew when he walked through the door if he was going to kiss me on the lips or punch me in the mouth."

No one should have to live with that kind of fear.

Most veterans groups being established take into account the feelings and fears of the wives and children and actively involve them in the meetings. It is a family matter. Domestic violence hurts everyone. The counseling has to involve the whole family. If any of what is written here sounds familiar, or you desire more information about delayed stress syndrome, you can write:

If you would like to become involved in a group dealing with delayed stress, contact:

None of the information you have read here is hard fact that applies to every Vietnam veteran. However, it's based on study and very personal experience.

The quotes herein are quotes from veterans I know. The experiences of domestic violence described herein are mine.

I am a casualty of the Vietnam war. If I could be granted one wish, it would be that I could be the last casualty.

Mr. EDGAR. Mr. Speaker, will the gentleman yield to me?

Mr. EVANS of Illinois. I yield to the gentleman from Pennsylvania.

Mr. EDGAR. Mr. Speaker, I would like to commend the gentleman in the well for his leadership on the issue of extending readjustment counseling centers.

The gentleman in the well joined in the hearings and we listened together as witness after witness told of the value of these veterans' centers.

While some of us were unsure whether to extend the program for 1 year, 2 years, or 3 years, I think the committee was right to settle on a 3-year extension and to incorporate the provisions of the gentleman of Illinois' (Mr. EVANS) bill into this legislation.

I think the gentleman's leadership has been outstanding. It is my hope that we can convince the other body of the wisdom of the 3-year extension.

One of the things that I was unable to say in my statement given the time constraint, was the fact that the study that is incorporated in this 3-year extension will take the Veterans' Administration almost 2 years to complete and that study will form the basis for future directions of the veterans' centers.

So I commend the gentleman for his leadership and I hope all of us will urge the other body to support the full 3-year extension.

Mr. EVANS of Illinois. Mr. Speaker, I thank the chairman of the subcommittee, the gentleman from Pennsylvania (Mr. ECHOLS) for his support and I thank the chairman of the full Committee on Veterans' Affairs, the gentleman from Mississippi, SONNY MONTGOMERY, for his support and on the Republican side, I think we had unanimous support on both sides of the aisle. We appreciate the efforts of Mr. HAMMERSCHMIDT and Mr. BILIRAKIS.

Mr. MONTGOMERY. Mr. Speaker, I yield myself 1 minute.

Mr. Speaker, I would certainly like to commend the chairman of the sub-

committee, the gentleman from Pennsylvania, Mr. ECHOLS, again, and also the ranking minority member of the subcommittee, the gentleman for Arkansas (Mr. HAMMERSCHMIDT), along with the 12 new members who are now serving on the Committee on Veterans' Affairs.

The attendance has been excellent. These Members are there for all of the markup sessions and do participate.

Mr. Speaker, the subcommittee responsible for this legislation has 12 new Members of Congress, and I want my colleagues to know that in all of my years on the committee, I have never seen a group more dedicated to their work than these Members. The attendance of our Members at all hearings and markup sessions has been excellent. Their contributions to the committee's work have been outstanding. I am grateful to Mr. EVANS of Illinois, Mr. KAPTUR of Ohio, Mr. HARRISON of Pennsylvania, Mr. MOLLOHAN of West Virginia, Mr. PENNY of Minnesota, Mr. STAGGERS of West Virginia, Mr. ROWLAND of Georgia, Mr. SLATTERY of Kansas, Mr. BRYANT of Texas, Mr. RICHARDSON of New Mexico, Mr. BILIRAKIS of Florida, and Mr. JOHNSON of Connecticut. These Members have already taken time to visit several hospitals at field hearings. They plan to make other site visits in the coming weeks. They want to make certain that veterans are receiving proper care at all VA facilities.

I am also grateful to members of the subcommittee who have served on the committee prior to this Congress, Mr. MICA of Florida, Mr. DOWDY of Mississippi, Mr. DASCHLE of South Dakota, Mr. HILLIS of Indiana, Mr. SOLOMON of New York, Mr. McEWAN of Ohio, Mr. SMITH of New Jersey, and Mr. GRAMM of Texas. Their time and attention to committee work has always been tremendous.

Mr. Speaker, this bill was reported unanimously by the Committee on Veterans' Affairs. It is a very good bill, and I urge its adoption.

Mr. CORRADA. Mr. Speaker, I rise in strong support of H.R. 2920, the Veterans' Administration Health Programs Amendments of 1983 which revises and extends certain health-care programs of the Veterans' Administration.

The bill would extend the veterans readjustment counseling program for 4 years. There is still a lot of wounds to heal and this extension would allow the counseling program to continue its good work. The bill also calls for a comprehensive study of the readjustment of Vietnam-era veterans to civilian life which would aid the readjustment counseling program in maximizing efforts in this area.

H.R. 2920 establishes an Advisory Committee on Women Veterans within the VA which would provide us with much needed information on problems affecting women veterans and how we can best address them. In

Testimony Before the
Subcommittee on Hospitals and Health Care
of the
U.S. House of Representatives' Committee on Veterans' Affairs

The Honorable Bob Edgar, Chairman

9:00 a.m., July 7, 1983
Edward J. Hines, Jr. Veterans' Administration Hospital

by
William D. Sawyer, M.D.
Dean
Wright State University School of Medicine

I am William D. Sawyer, M.D., Dean of the Wright State University School of Medicine in Dayton, Ohio. I appreciate the opportunity to report on the development of the School and of its affiliation with the Dayton Veterans' Administration Medical Center. The Veterans Administration provided the School substantial support--over \$29,000,000--through Public Law 92-541 and a 12-month extension of expenditure authority by Public Law 97-15. The Teague-Cranston act authorized support of new state medical schools developed with a major reciprocal relationship with Veterans' Administration hospitals. The ultimate purpose of the law was to provide "the best possible medical care for the Nation's veterans." There was conviction that the quality and the pace of the care of veterans would be enhanced through new or expanded programs of medical education at existing Veterans' Administration medical centers.

Today, I emphasize three points:

- (i) The Wright State University School of Medicine is meeting the goals and expectations of the University, the community, the State, and the Federal government, including the Veterans' Administration;
- (ii) The Dayton Veterans' Administration Medical Center is an integral part of the program of the School of Medicine, and the arrival of the School has had a positive impact on the care of veterans in west central Ohio; and
- (iii) The completion of funding under P.L. 92-541 should not be taken as a signal that the purposes have ended, but rather as the beginning of a transition period in which both the State of Ohio and the Veterans' Administration must meet their implied commitments to the continued support of the School and of the Dayton Veterans' Administration Medical Center, respectively.

My first point is the progress of the School of Medicine. The School was created by an act of the Ohio legislature in 1973. The School bases its clinical program in community facilities, the Veterans' Administration Medical Center, and the Wright-Patterson Air Force Medical Center and emphasizes the preparation of physicians for careers in primary care. The timetable called for both the graduation of the first class and full accreditation in 1980. Progressive expansion to the full enrollment of 100 students per class was projected to be complete in 1982. This timetable was kept. Perhaps more importantly, the School's development was achieved without a major disruption within the parent academic institution or among the physicians and hospitals of the community.

Two aspects of the School's mission warrant special comment. These are (i) the preparation of physicians for careers in primary care, and (ii) the creation of new knowledge.

Of the School's 238 graduates, 68% have entered residency training in primary care, that is, in Family Practice, Internal Medicine, or Pediatrics. The results for Family Practice are particularly gratifying to us. Of our recent graduates, 30% are training in Family Practice; this is more than double the proportion among the graduates of the other allopathic medical schools in Ohio. The School's emphasis on preparation for primary care has not, however, prevented graduates who seek training in other specialties and subspecialties from gaining access to training programs of their choice. Wherever they have gone for graduate medical training, our graduates have been well received. Systematic evaluation through contact with residency-program directors indicates that better than 90% of our graduates are perceived as being equal to or better than others in their residency peer group.

In its brief history, the Wright State University School of Medicine has become a strong and increasing contributor both of new fundamental knowledge and of the application of research and technology to the betterment of the human condition. Within the program, several efforts have gained national and international recognition.

Dr. Jerrold Petrofsky and his associates have brought new hope to paraplegics and quadraplegics through computer-controlled functional electrical stimulation of muscles.

The School's Hipple Laboratory for Cancer Research is examining hormones that govern the production of blood cells in an effort to understand the processes responsible for leukemia and to develop innovative approaches to the management of malignancies. Dr. Takaji Miyake, Senior Investigator, has recently demonstrated a new hormone, granulopoietin, that controls the production of certain white blood cells.

The Cox Heart Institute of the School of Medicine pioneered the use of electronic monitoring and computers in the management of patients with acute heart disease. More recently, the Institute has concentrated on the prevention of coronary heart disease and hypertension.

The School's program in Aerospace Medicine attracts students from throughout the world to this country's only civilian aerospace medicine residency. Faculty and graduates are playing a leading role in the medical aspects of our nation's space effort and in making aviation safer.

Dr. Harvey Siegal leads the School's innovative educational, research, and service programs on alcoholism, especially in relation to driving while intoxicated, and other substance abuse in adults and in teenagers. Dr. Siegal's approach emphasizes management on an out-patient basis, an effort that is far less costly than in-patient alcoholism and drug treatment. Evaluation indicates that Dr. Siegal's results may be superior to those of the more expensive approaches. Several states are currently working with Dr. Siegal to initiate similar programs.

I hope that these few examples convey the scope and the progress in our research program and how it is "paying off."

My second point is the programmatic integration of the Dayton Veterans' Administration Medical Center and the School and the positive impact of developments at the Center on the care of veterans. The Dayton Center has 342 beds for acute care and 148, 284, and 780 beds for intermediate, nursing, and domiciliary care, respectively. In the past decade the Center's program has advanced importantly in the scope of available medical services. For example, the physician staff has increased by 62%, and the number who are board certified in their fields has more than doubled. Staff physicians are medical school faculty members.

Although the Center's Brown Hospital is not a tertiary level facility, important new services have been added such as plastic surgery, ophthalmological surgery, expanded hemodialysis, home peritoneal dialysis, liaison psychiatry, expanded endoscopy, electroneurophysiology, expanded pulmonary medicine, and modern diagnostic laboratory procedures. Technology and equipment have been enhanced. Fewer patients require referral to facilities outside their home area. The average length of stay has declined.

Four of the five medical residency training programs at the Center have been integrated into the graduate medical education programs of the School of Medicine. One indication of the change in the residency programs at the Veterans' Administration Medical Center consequent to integration is the increase in the proportion of residents who are graduates of American medical schools, from 0% to 70%.

In addition to receiving training, the residents offer both the important intellectual ferment of youth and valuable service in their patient care activities. In their service role, the residents are well supervised. During the past three years in General Surgery, for example, an attending staff surgeon has been "scrubbed" in from 80 to 85% of resident surgeries. In nearly all of the rest, the attending staff surgeon was present in the operating room.

The integration of the Medical School and the Veterans' Administration Medical Center is also reflected in the School's full four-year educational program. One half of the required clinical clerkship assignments are at the Veterans' Administration Center. These clerkship assignments are the most popular among the several choices available to the medical students and highly sought. This reflects the commitment of the teaching staff and the educational opportunity at the Center.

New construction at the Center provides two important buildings for the School's educational programs. These superb facilities will be attractive offerings in the Center's and the School's current joint efforts at recruiting for replacement in recently vacated, important staff positions at the Center.

My third point concerns the expectations of continuing support from both the State of Ohio and the Veterans' Administration. Ohio has provided substantial support to the School as facilities, capital equipment, and operating budget, and the State is continuing to meet its commitments. The School will occupy a substantial portion of two new buildings, one under construction and one in final plan. The School is currently operating within a budget of approximately \$20,000,000 exclusive of the costs of residency programs; \$8,200,000 is directly from the State. Modest reserves and endowments have been established. Research and development support will significantly exceed \$4,000,000 this year, placing the School ahead of many of the others of similar size and age.

It is important for this joint enterprise that began under Public Law 92-541 that the Veterans' Administration continues the support of the Dayton Veterans' Administration Medical Center as a major, academically affiliated entity in its hospital and health-care system. Both fiscal and vigorous administrative support are required. Broad, quality patient care capabilities must be sustained. For facilities of modern standards, further renovation, construction, or both should be implemented. Long range planning and resource allocation processes should neither ignore nor diminish the achievements gained by the previous investment of both dollar capital expended from P.L. 92-541 in Ohio and the human capital of the faculty, staff, and students of the School and the Center.

To conclude, we of the Wright State University School of Medicine are proud of our development and achievements, both as an institution and as a partner with the Dayton Veterans' Administration Medical Center. We hope that the Veterans' Administration, this Committee, and the Congress share that pride. We intend to keep our commitments and urge the continuation of the Veterans' Administration's commitment through on-going, quality support of the veterans' care and educational efforts at the Dayton Veterans' Administration Medical Center. Working together, we can contribute further to the well-being of veterans and mankind generally.

The Subcommittee on Hospitals and Health Care

Testimony of

James E. Eckenhoff, M.D.

Dean, Northwestern University Medical School

President, McGaw Medical Center of Northwestern University

Mr. Chairman, ladies and gentlemen! First my apologies for the tardiness of a written statement. The invitation to speak and request for a prepared statement arrived in my office the day I was to leave for 2 weeks in London to participate in an invitation only Symposium on the Quality of Care in Anesthetic Practice in England sponsored by The Royal Society of Medicine. Unfortunately for me, I was cast in the role of a chairman of those sessions and as the summator of the Symposium. It is not an easy assignment to be put in the position of an American telling English physicians what needs to be done to improve their quality of health care. I feel much more comfortable speaking to the group assembled here.

First, let me describe to you Northwestern University Medical School and follow that with a description of the McGaw Medical Center of Northwestern University. Northwestern University is a member of the Big Ten group of Universities, is the smallest one and the only one that is a private University. The principal campus is in Evanston, Illinois, with a Chicago campus 13 miles away in center city where the Schools of Dentistry, Law, Medicine, and Continuing Education are located. The Medical and Dental Schools have combined basic science departments. The Medical School has 2050 faculty of whom 130 are full time in the basic sciences. A majority of the clinical faculty are non-University salaried, most deriving all of their income from private practice and the remainder are partially University salaried with their main income coming from hospitals for administrative and

supervisory activities or from a separately incorporated not-for-profit group practice foundation with 190 physicians participating.

In the Medical School there are 170 medical students in the first two years and 182 in the third and fourth years. Northwestern was one of the first medical schools in the country to initiate a 6 year program in medical education, now 22 years ago. Sixty students each year are admitted to the 6 year program, spend two years of intensive collegiate study on the Evanston Campus and are guaranteed admission to the Medical School upon satisfactory completion of those two years. The remaining 110 students are selected from among approximately 6000 applicants, 55 drawn from Illinois applicants and the other 55 from throughout the United States. Thirteen percent of our students are from California and 8 percent from New York with 22 states and 58 universities represented in last years entering class. Twelve transfer students are admitted to the third year class, mostly from foreign medical schools selected via competitive interviews and competitive examinations. The predominate attention of the students for the first 1½ years is in learning basic sciences and the remaining 2½ years in clinical medicine.

In addition to medical students, the Medical School is responsible for programs in Nursing, Physical Therapy, Public Health and Community Medicine, Psychology, and in Graduate work in the basic sciences leading to the Ph.D. degree.

Finally, the Medical School is responsible for the Graduate Medical Education of 820 physicians, 750 of whom are housestaff, more commonly called residents, and 70 fellows, individuals who have completed their required post-graduate training but are gaining extra experience usually in specialty areas. All specialties of medicine are represented and the selection of housestaff is highly competitive,

165 positions available each year for which there are about 4000 applicants.

Secondly, a description of the McGaw Medical Center of Northwestern University. Northwestern University does not own or operate a hospital. It is affiliated with 4 private hospitals and the Veterans Administration Lake Shore Hospital, all including 2830 beds and comprising the McGaw Medical Center. In addition to the VA Hospital, there are Northwestern Memorial Hospital and the Rehabilitation Institute of Chicago, all adjacent to the Medical School. The Children's Memorial Hospital is located 15 minutes north and Evanston Hospital 30 minutes away in Evanston in proximity to Northwestern's Evanston Campus. All hospitals have their own Boards of Directors except Lakeside. There are three other hospitals, Columbus-Cuneo-Cabrini, St. Joseph's and Lake Forest, which have teaching agreements with the Medical School but are not a part of the Medical Center. The Medical Center can be looked upon as a loose confederation of hospitals with the University, each supplying members to the Center's Board of Directors, but no decision of the Board is binding on any member institution.

Perhaps the principal binding force of the Medical Center institutions has been education of medical students and housestaff. Most physicians who practice in the Center hospitals are University faculty members, and all housestaff in the Center are members of the Integrated Housestaff Program of the Center. All students rotate for their clinical training among the Center hospitals and with one exception, all housestaff are selected through the Office of Graduate Medical Education in the Medical School and rotate freely among the various institutions for their training. An important point here is that with the exception of the Internal Medicine Program at Evanston Hospital, no training program is defined as a "hospital" program but rather all are Center programs. Thus housestaff assigned at any time to Lakeside VA Hospital participate in a teaching program

fully integrated among all hospitals. The particular benefit to Lakeside is a high calibre housestaff, all of whom are American Medical Graduates and all of whom are constantly supervised by faculty of the Medical School. We believe Lakeside VA Hospital has one of the highest quality housestaff programs in the entire country.

Each clinical chairman in the Medical School is charged with overseeing the standard of medical care of Lakeside VA Hospital in their respective specialties. The departmental professional staff is selected and approved by the chairman and since, with the rare exception, all are University faculty, they must be approved by the Medical School's Appointments and Promotions Committee. A Dean's Committee meets monthly and at each meeting one department or section gives a detailed report on its patient care and educational programs. A member of an Armed Forces organization is present and participates in discussion. The service chief at Lakeside reports academically to the chairman of the School's department, is a member of the department's executive committee, and with the consensus of the Hospital Director and the Dean, coordinates the teaching and research programs with the chairman. All chairmen, and the Dean, consider Lakeside as one of our principal teaching hospitals and judging from both student and housestaff evaluation, it is one of our best rotations. Most chairmen and many faculty consult at Lakeside on a regular basis. As a Dean and former chairman of the Department of Anesthesia at Northwestern University, I regularly spend 1½ to 2 hours weekly working in the operating rooms at Lakeside.

Northwestern is dedicated to the appointment of quality professional staff and graduate trainees and the goals apply to Lakeside as well. This interest is of sufficient importance that appreciable supplements to VA salaries to attract quality faculty may come from Medical School departments, not from University

sources since the University supplies only about 10% of my more than \$56 million budget. In many instances these supplements come from group private practice income, as for example through the practice Foundation. Many faculty and fellows work full time or part time at Lakeside, doing research and providing patient care at no cost to the Veterans Administration. Not only housestaff are integrated into the Medical Center program but Lakeside professional staff are considered bona fide University faculty and are eligible for University tenure. The Chief of Staff is a Professor of Medicine and an Associate Dean of the Medical School and the Associate Chief of Staff for Research is an Associate Professor of Medicine. The Chief of Staff attends all meetings of the School's Council of Chairmen and is a member of the University's Medical Council.

From a Dean's perspective, I view the relations between Northwestern's Medical School and Lakeside Hospital as being very close. I believe all of our chairmen do too. Further, having worked with 6 previous Hospital Directors, the rapport between the present Director and my office has never been so close, nor, I believe, has the condition of the Hospital or the quality of service delivered to the veteran patients at Lakeside been so good. From a perspective as President of the Medical Center, I can also say that relationships between the presidents of all of the hospitals and common interest in the Veterans Hospital problems is excellent.

We have done our best to make our Medical Center run in a cooperative and cost effective manner. We believe that all of our facilities should be used in the most efficient manner and in the best interest of quality care. To that end, we hope that where possible, medical centers such as ours be given the maximum flexibility, so that our Lakeside Hospital is not excluded in any McGaw Medical Center program that is in patient care interests because of rigid government rules.

Certainly Mr. Moore has done a superior job in working toward the common good. We also believe that a hospital that is engaged in educational and research programs assures its patients of quality medical care. A hospital staff not exposed to the challenge of teaching young students and physicians, and not accustomed to the intellectual challenge of research programs, is unlikely to be distinguished. We believe the best interests of excellence in medical care of the Armed Forces veterans of this country are served by close association with teaching institutions. Specifically referring to our type of private university where faculty work part time in private practice and part time in research and teaching, we question regulations that would prohibit Veterans Administration support of research to those who are not full time employees of Veterans Hospitals. A rigid regulation that prohibits research support to part time professional staff is not in the interest of quality health care to our veteran population. Evidence suggests lack of governmental support for such activities in United Kingdom institutions is compromising quality health care delivery there.

Finally, the McGaw Medical Center embarked two years ago in a program establishing the McGaw Center on Aging. One year ago a Director for the Center was recruited and we are busily building up our programs in this area. Our Director is also Medical Director for the Presbyterian Home in Evanston where the average age of the patients is 86 years and who is also the Chief of the Section on Geriatrics at Evanston Hospital. On July 1, an associate director for Geriatric Medicine was also appointed on the Chicago Campus. The Center's directors have had several conferences with the Chief of Medicine at Lakeside, who will be a full partner in the Programs on Aging of the Medical Center. This will be a fully integrated program. Ours will not be a patient care program but rather an educational, research and coordinate effort.

Thank you for the privilege of presenting this brief overlook of our activities and its relationship to our Lakeside Veterans Hospital. I will be pleased to respond to questions.

JEE

STATEMENT OF
MR. MICHAEL JACKSON
REGIONAL MANAGER, REGION IV, READJUSTMENT COUNSELING PROGRAM
DEPARTMENT OF MEDICINE AND SURGERY
VETERANS ADMINISTRATION
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
HOUSE OF REPRESENTATIVES
AT HINES VA MEDICAL CENTER
CHICAGO, ILLINOIS

JULY 7, 1983

Mr. Chairman, I am pleased to be here today to discuss the provision of readjustment counseling to Vietnam-era veterans in Region IV. The states of Illinois, Indiana, Michigan, Missouri, Ohio and Wisconsin comprise Region IV. There are 18 Vet Centers within the Region.

In January 1982, 14 Vet Centers were fully operational; all 18 Vet Centers became fully operational as of January 1983, with a total of 79 staff - 73 percent either Vietnam or Vietnam-era veterans. These centers were supported logistically by 14 VA Medical Centers and one VA Outpatient Clinic. While programmatic responsibility for these 18 sites rests with the Regional Manager and the Assistant Regional Managers for Administration and Counseling, a full range of readjustment counseling services are provided within these centers. The total number of Vietnam veterans served to date in Region IV is 43,388; of this total, approximately 75 percent have been combat veterans,

and the remaining 25 percent Vietnam-era veterans. Early on in the program, it appeared that the Region was having only limited success involving Blacks, native Americans, Hispanics, and females in the Vet Centers. However, the number of Black veterans now seen represents approximately 28 percent of the total number, with Hispanics representing approximately 3 percent and native Americans approximately 1 percent. Female veterans represent approximately 2 percent.

Our workload data indicate that we have had approximately 111,489 visits to our Vet Centers for service since the first Vet Center in this Region opened at Chicago in January 1980. The number of Vietnam veteran family members seen to date in this Region is 24,684. At this time, there are 56 contract/fee providers within this Region providing readjustment counseling services to veterans and their families. There are an estimated 1,412,860 Vietnam veterans residing within this Region, the majority of whom are located within urban centers or metropolitan areas.

Within Region IV, 8 new Team Leaders have been recruited since January 1982 to either replace those who had resigned or had been promoted or to lead a new team. Twenty-one additional team members have been hired since that date, as replacements for staff who had left or as members of new teams.

The current state of affairs in this Region finds the Regional Manager's Office staffed with two assistants (one for Administration and another for Counseling Services) and two secretaries. All Regional Managers' Offices have been equipped with word processors. Obviously, these additions have improved accomplishment of the tasks at hand; however, there usually seems to be more tasks than time and people to accomplish them. The additional personnel and the benefits of a word processor have assisted in diminishing the management-by-crisis method of operation.

The VA Central Office Program Director has been successful in augmenting the VACO staff with three Assistant Directors and additional clerical staff. Since January 1982, the distribution of a Program Circular (June 1982), Program Guide and Program Policy Guides 1 and 2 have been welcome initial efforts toward systematizing our program operations. In January of this year, revised guidelines and new operating instructions for the contract/fee program were issued. These changes helped to streamline referral procedures and outline areas of responsibility of VA organizational elements. In Fiscal Year 1982, team leaders were instructed to develop detailed budget plans for the Vet Centers in corroboration with VA fiscal offices. These efforts have also been helpful for planning purposes. VA Medical Center personnel have learned more about Outreach Centers, and Outreach staff have, through experience and training, gained a better grasp of VA regulations and established operational procedures. In order for this learning process to continue, all team leaders in the Region were instructed to have supervisors training given by VA Central Office Personnel Service.

Excellent Regional-wide training conferences and several District-level conferences have been held within the past 12 months. Most of these have been supported by the Mid-Atlantic Regional Medical Education Center (RMEC) with a combination of VA and non-VA faculty. These training experiences have helped in the continuous orientation of Outreach staff to the VA system and procedures. Of equal significance, these experiences have allowed traditional VA staff to gain more of an appreciation for the people of Operation Outreach and what we do. The training for Regional Managers remains quite limited although options are being explored on the national level to improve this situation.

The national coverage of the "Salute to Vietnam Veterans" in Washington, DC, in November 1982 has helped improve the morale of all Vietnam-era veterans, including the

Vet Center staffs. The commendations and cash awards given to outreach staff from across the country who provided emergency readjustment counseling to veterans and their families during that week meant a great deal to our staffs. Special acknowledgements and awards for outreach staff have been initiated by certain Medical Center Directors for special contributions and crisis interventions that have defused dangerous situations. The issuance of special contribution and performance awards by my office has been an attempt to begin to deal with the matter of the long-neglected recognition of Vietnam-era veterans.

The sense of isolation, the stressful nature of outreach work, the frustration and uncertainties mentioned earlier, and the fact that many of the outreach staff are Vietnam combat veterans themselves, prepares the stage for our staff to experience emotional burnout. Our program needs a mechanism for taking care of its own -- an employee assistance program staffed by clinicians sensitive to the work and related problems and professionals whom staff would willingly see with no fears of their confidentiality being violated. In order to continue "to care for him who shall have borne the battle and for his widow and his orphan" in the Vietnam War, contained fiscal autonomy and integrity is essential.

During the past 16 months, the personnel within this Region have met the challenges of program transition and growing sophistication. Their adjustments to these changes has not been without pain; we have lost some comrades along the way. For most of the 79 employees in this Region, their participation within this program has been a mission, a crusade, if you will, rather than a job. Mr. Chairman, on behalf of them, I wish once again to express my appreciation for being invited to appear before this committee.

This concludes my statement. I will be pleased to answer any questions you or members of the committee may have.

STATEMENT OF
HAROLD BLECHMAN
DEPARTMENT ADJUTANT
DISABLED AMERICAN VETERANS
DEPARTMENT OF ILLINOIS
BEFORE THE
SUBCOMMITTEE ON HOSPITALS
AND HEALTH CARE
JULY 7, 1983

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

ON BEHALF OF THE 780,000 MEMBERS OF THE DISABLED AMERICAN VETERANS, I WISH TO THANK YOU FOR THE INVITATION TO PARTICIPATE BEFORE YOUR SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE.

IT IS OUR DESIRE AND CONCERN FOR THE VETERANS OF THE STATE OF ILLINOIS, NORTHWEST INDIANA AND SOUTHERN WISCONSIN TO REVIEW PROBLEM AREAS ON HOSPITAL AND HEALTH CARE IN THE CHICAGO METROPOLITAN AND SURROUNDING AREAS. WE KNOW AMERICA IS AGING AND THE LIFE SPAN OF MOST PEOPLE IN OUR SOCIETY IS INCREASING WHILE OUR NATIONAL BIRTH RATE HAS DECLINED. THERE ARE NEARLY 25 MILLION AMERICANS WHO ARE NOW 65 YEARS OF AGE OR OLDER. WE CAN EXPECT TO LIVE INTO OUR EIGHTIES AND BY THE YEAR 2000 THE POPULATION OF THE UNITED STATES WILL ABOUT TRIPLE. WE HAVEN'T DONE ANY LONG-RANGE PLANNING TO PREPARE FOR THE IMPENDING TIDAL WAVE OF CHANGE IN OUR POPULATION.

MR. CHAIRMAN, IN THE STATE OF ILLINOIS WE HAVE A TOTAL VETERANS POPULATION OF 1,348,000. THIS DOESN'T INCLUDE THE VETERANS FROM NORTHWEST INDIANA AND SOUTHERN WISCONSIN THAT REQUIRE THE USE OF VA FACILITIES IN ILLINOIS BECAUSE OF THE CLOSE PROXIMITY TO THEIR HOMES. IN ILLINOIS WE HAVE 17,000 WORLD WAR 1 VETERANS, 529,000 WORLD WAR II VETERANS, 268,000 KOREAN CONFLICT VETERANS AND 388,000 VIETNAM VETERANS. THE AVERAGE AGE OF THESE VETERANS ARE; WW I VETERANS 87.3, WW II 62, KOREAN CONFLICT 52.4 AND VIETNAM VETERANS IS CLOSE TO 40. ILLINOIS HAS SIX (6) VA MEDICAL CENTERS FOR A TOTAL OPERATING BED CAPACITY OF ONLY 4,341.

THE VA IN ILLINOIS WILL HAVE A TOTAL OF 490 BEDS IN THEIR NURSING HOME CARE UNIT, UPON COMPLETION OF THE 60 BED UNIT WHICH IS UNDER CONSTRUCTION AT MARION VAMC. WEST SIDE AND LAKESIDE VA MEDICAL CENTER,

WHICH ARE LOCATED IN CHICAGO, DOESN'T PROVIDE NURSING CARE SERVICES. WE CAN PREDICT WITH REASONABLE CERTAINTY, THAT MORE BEDS ARE NEEDED FOR THE VETERANS THAT REQUIRE THIS TYPE OF CARE. WE ENTERTAIN YOUR CONSIDERATION THAT LAKESIDE AND WEST SIDE VA MEDICAL CENTERS BE FUNDED TO PROVIDE NURSING CARE SERVICES BECAUSE THEY ARE LOCATED CLOSE TO PUBLIC TRANSPORTATION, WHICH PROVIDES ACCESS TO THE FAMILY MEMBERS OF THE VETERAN. WE DON'T BELIEVE WE HAVE SUFFICIENT HOSPITAL BEDS IN ILLINOIS IN WHICH TO PROVIDE FOR THE VETERAN. THE JOINT UTILIZATION BY THE VA AND THE MILITARY HOSPITALS IN THIS AREA ARE NOT PRACTICAL BECAUSE OF THE INFLUX OF CHAMPUS DEPENDENTS WHO ARE NOW ACCORDING TO LAW, REQUIRED TO USE A MILITARY HOSPITAL IF THEY RESIDE WITHIN A 60 MILE RADIUS. (IT USED TO BE A 40 MILE RADIUS). AS OF JANUARY THIS YEAR, THE VA OPERATING BED LEVEL WAS 79,943, WITH AN AVERAGE DAILY CENSUS OF 64,730. THIS GIVES THE VA HOSPITALS AN OCCUPANCY RATE OF 81 PERCENT, WHICH IS ABOVE OPTIMAL RATE CITED BY THE PRESIDENT'S PRIVATE SECTOR SURVEY ON COST CONTROL (PPSSCC).

THE FISCAL YEAR 1984 BUDGET REQUEST ALSO ASSUMES NO INCREASES IN THE AMOUNT OF HEALTH CARE THE VA WILL DELIVER TO VETERANS DURING THE COMING YEARS. IT PROJECTS RELATIVELY LITTLE CHANGE FROM ONE YEAR TO THE NEXT IN THE NUMBER OF OUTPATIENT VISITS, EPISODES OF HOSPITALIZATION, ETC. THIS IS COMPLETELY OUT OF WHACK.

THE VA FACES A MUSHROOMING DEMAND FOR MEDICAL TREATMENT DUE TO THE AGING OF WORLD WAR II AND KOREAN WAR VETERANS. THESE VETERANS ARE AT OR APPROACHING THE AGE WHEN THE NEED FOR MEDICAL CARE INCREASES RAPIDLY. IN ADDITION, THE AVERAGE AGE OF VIETNAM ERA VETERANS IS NOW PUSHING 40, MEANING THAT CARE NEEDS AMONG THESE VETERANS ARE ALREADY BEGINNING TO CLIMB.

EVERYONE IN VETERANS' AFFAIRS IS AWARE OF THESE FACTS. AND VA OFFICIALS HAVE BEEN NERVOUSLY TALKING ABOUT THE COMING "CRUNCH" IN THEIR MEDICAL SYSTEM FOR SEVERAL YEARS. BUT, IF WE'RE GOING TO AVOID CRISIS WHEN THE CRUNCH HITS, THE TIME TO START PREPARING FOR ACCELERATED DEMAND IS RIGHT NOW. IN FACT, MUCH MORE SHOULD HAVE BEEN DONE UP TO THIS POINT. THE VA MEDICAL SYSTEM NEEDS EXPANSION, NOT CONTRACTION.

FOR THE PAST SEVERAL YEARS, INCREASES IN VA MEDICAL FUNDING HAVE NOT KEPT PACE WITH INFLATION IN THE HEALTH CARE ECONOMY, WHICH HAS CONSISTENTLY SURPASSED INFLATION IN THE GENERAL ECONOMY. DURING THE PAST YEAR COSTS THROUGHOUT THE HEALTH CARE ECONOMY CLIMBED A WHOPPING 22 PERCENT, EVEN THROUGH INFLATION IN THE AMERICAN ECONOMY AS A WHOLE SLOWED SIGNIFICANTLY.

THE 5-PERCENT INCREASE THE WHITE HOUSE BUDGET REQUEST RECOMMENDS IN VA MEDICAL FUNDING DOESN'T COME CLOSE TO THE 11-PERCENT COST INCREASES EXPERIENCED IN THE OVERALL HEALTH CARE ECONOMY. THOUGH THE VA MEDICAL SYSTEM IS MORE EFFICIENT THAN THE PRIVATE AND NOT-FOR-PROFIT HEALTH CARE SYSTEMS, THE STRAIN OF THIS YEARLY UNDERFUNDING HAS BEEN SHOWING IN THE VA SYSTEM FOR SOME TIME.

WE ARE ALSO CONCERNED BY THE WAY THE FISCAL YEAR 1984 BUDGET REQUEST TREATS PROSTHETICS AND REHABILITATION RESEARCH, WHICH IS AIMED AT THE NEEDS OF SERVICE-CONNECTED DISABLED VETERANS. FOR SEVERAL YEARS, THIS TYPE OF RESEARCH HAS TAKEN A BACK SEAT TO GENERAL BIOMEDICAL AND BASIC SCIENCE RESEARCH IN THE VA MEDICAL SYSTEM'S RESEARCH BUDGET.

IT HAPPENED AGAIN IN THE FISCAL YEAR 1984 BUDGET REQUEST. WE DON'T BLAME THE WHITE HOUSE FOR THIS. THE PRIORITIES OF THE VA MEDICAL SYSTEM'S RESEARCH PROGRAMS ARE ESTABLISHED WITHIN THE VA. WE THEREFORE, BLAME THE VA FOR THE PROPOSED CUTS IN REHABILITATION RESEARCH IN AN FISCAL YEAR 1984 BUDGET REQUEST THAT INCREASES THE MEDICAL SYSTEM'S OVERALL RESEARCH BUDGET.

THE DAV CAN'T UNDERSTAND WHY RESEARCH DESIGNED TO BENEFIT SERVICE-CONNECTED DISABLED VETERANS MUST CONSISTENTLY BE TREATED AS A STEPCHILD IN THE VA'S RESEARCH PROGRAMS. AFTER ALL, AREN'T THE NEEDS OF WARTIME DISABLED VETERANS THE JUSTIFICATION FOR HAVING VA MEDICAL RESEARCH PROGRAMS IN THE FIRST PLACE? I KNOW OTHER FACTORS ARE INVOLVED HERE. BUT THOSE WHO ESTABLISHED THE RESEARCH PRIORITIES IN THE VA DON'T SEEM TO UNDERSTAND WHO THE VA MEDICAL SYSTEM WAS ESTABLISHED TO TREAT. SERVICE-CONNECTED DISABLED VETERANS SHOULD BE THE HIGHEST PRIORITY THROUGHOUT THE VA HEALTH CARE SYSTEM, INCLUDING ITS RESEARCH PROGRAMS.

WE FEEL THE FEDERAL HIRING FREEZE AND COST CUTTING MEASURES IS THE PRINCIPAL CULPRIT CAUSING AN ADVERSE EFFECT ON VETERAN'S HEALTH CARE.

WHEN A PROGRESSIVE LOSS OF PERSONNEL CONTINUES WITHOUT REPLACEMENT THERE IS NO WAY THE SYSTEM CAN FUNCTION SMOOTHLY.

BECAUSE OF A SHORTAGE OF QUALIFIED PERSONNEL, THE VETERAN IS EXPOSED TO EXTREME AND SOMETIMES CRUEL DELAYS BEFORE SEEING A TREATING DOCTOR, AT TIMES EVEN ON AN EMERGENCY BASIS, THERE ARE LONGER LINES AT THE PHARMACY, THERE IS LESS CONTROL OF TREATMENT FOLDER, MANY ARE MISPLACED OR LOST AND ARE NOT AVAILABLE TO THE EXAMINING DOCTOR. THIS BECOMES EXTREMELY IMPORTANT PARTICULARLY WHEN THERE IS A NEW DOCTOR ASSIGNED TO THE VETERAN AND HE HAS TO START FROM SCRATCH. ALSO, A CONSISTENT PATIENT AND DOCTOR RELATIONSHIP IS REALLY NEVER ACHIEVED BECAUSE OF A CONSTANT ROTATION OF DOCTORS. AND THE AGE OLD PROBLEM OF LACK OF COMMUNICATION BETWEEN PATIENT AND DOCTOR CONTINUES TO EXIST PRIMARILY BECAUSE OF THE LANGUAGE BARRIER. IN THE FIELD OF EVALUATION FOR COMPENSATION OR PENSION, MANY DOCTORS ARE NOT FAMILIAR WITH THE PROCEEDURES TO BE USED FOR RATING PURPOSES THEREBY CREATING INADEQUATE EXAMINATIONS. THE DAV WAS MOST INSTRUMENTAL IN HAVING POST TRAUMATIC STRESS DISORDER RECOGNIZED AS A MEDICALLY ACCEPTED DISABILITY, BUT NOW ENCOUNTERS SOME RESISTANCE FROM SOME DOCTORS TO ACCEPT THIS AS A BONAFIDE RATEABLE ENTITY. WE HAVE ONLY LIGHTLY TOUCHED ON THE SUBJECT MATTER, BUT WE FEEL WARMLY CONFIDENT CONGRESSMAN EDGAR, IN HIS CAPACITY, IS COGNIZANT OF THE SERIOUSNESS OF THE PROBLEMS THAT EXIST AND THRU HIS EFFORTS A VAST IMPROVEMENT WILL BE MADE.

IN REGARDS TO THE CURRENT OUTPATIENT FACILITY AT NORTH CHICAGO MEDICAL CENTER THE DAV OF ILLINOIS IS IN FULL SUPPORT OF THE CONSTRUCTION OF A CENTRALIZED OUTPATIENT CLINIC ON THE CURRENT GROUNDS AT THE NORTH CHICAGO MEDICAL CENTER. HOWEVER; DUE TO THE COST FACTOR INVOLVED, BASED ON THE HISTORICAL DESIGNATION OF CURRENT BUILDINGS, CONSIDERATION SHOULD BE GIVEN FOR THE UTILIZATION OF COST SHARING WITH THE DEPARTMENT OF DEFENSE (DOD) AND MAINLY FIVE (5) FLOORS OF THE U.S. NAVAL HOSPITAL IN GREAT LAKES, WHICH ARE STANDING IDLE. IT IS FELT GREATER EMPHASIS IN THE GEOGRAPHIC AND IMPROVED OUTPATIENT FACILITY WOULD FACILITATE A HIGHER QUALITY OF HEALTH CARE TO DISABLED VETERANS.

THAT CONCLUDES MY TESTIMONY, MR. CHAIRMAN, I AGAIN WISH TO THANK YOU AND THE MEMBERS OF THE COMMITTEE FOR PERMITTING US TO PROVIDE OUR VIEWS ON HOSPITAL AND HEALTH CARE ON BEHALF OF THE DISABLED VETERANS IN THE GREAT LAKES REGION.



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STATEMENT OF

PATRICK DE MAURO, STATE SERVICE OFFICER
 VETERANS OF FOREIGN WARS OF THE UNITED STATES
 DEPARTMENT OF ILLINOIS

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
 UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

INPATIENT AND OUTPATIENT VA HEALTH CARE IN THE GREAT LAKES REGION AS REPRESENTED
 IN THE METROPOLITAN CHICAGO AND SURROUNDING AREAS, INCLUDING NORTHWEST INDIANA

CHICAGO, ILLINOIS

JULY 7, 1983

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

Thank you for the privilege of appearing before this distinguished committee to present the views of the Veterans of Foreign Wars, Department of Illinois; as relating to the Veterans Administration delivery of health care within VA Medical District 17. My name is Patrick DeMauro, State Service Officer for the Veterans of Foreign Wars, Department of Illinois, and I have been designated by the State Commander, Dwight Tanner, to express the following remarks.

We are told that the results of the 1982 census revealed the veteran population peaked at 30,143,000 and that this pinnacle was reached in November 1982. We are also told that the number of veterans over age 65 was 3.3 million in 1981 and that this is projected to increase to 7.7 million in 1990. While we must exercise prudence in such population projection, one outlook remains rather clear -- there will have to be some rather dramatic changes within the Veterans Administration

health care delivery system to meet the changing needs of a "graying" veteran population.

Changes in the delivery of health care to meet the special requirements of an aging population will, of course, primarily be based on the following assumptions:

- 1) Eligibility for admission and treatment in VA facilities will not change in accordance with current statutes.
- 2) The current VA budget will keep up with the rate of inflation despite the administration's goal to control federal spending.
- 3) No major breakthrough in treatment which would significantly alter the pattern of morbidity and mortality.
- 4) There will not be a national health insurance program.
- 5) Incentives to recruit, develop, and maintain a highly qualified work force will remain.
- 6) And consumer groups, such as the Veterans of Foreign Wars, will maintain strength and vitality so as to continue to protect the integrity of the Veterans Administration.

Contrary to most popular belief, the Veterans Administration at present does not deliver a holistic concept of health care. While emphasizing on medicine and surgery, as a primary function, only a pioneering effort is placed on geriatric care, nursing care, rehabilitation, extended care, alcoholic and drug abuse substance programs, home care, health maintenance programs, and preventive medicine. Other high quality alternatives to hospitalization considered as a vital part of the delivery system are the home based hospital care programs, adult care centers, ambulatory surgery, and adoption of night clinics for certain specialities.

Unfortunately, the VA may find it difficult to implant many of these improvements without the complete involvement and cooperation of its affiliates, the American medical schools, which so far because of their primary mission (teaching, research, and patient care) have placed little emphasis or importance on nonacute medical approaches.

A viable health delivery care system must include noninstitutional alternatives which not only serves to benefit patients but assists in relieving pressure on hospital resources. A good example of such care would be the delivery of medical, nursing, social, and rehabilitative services by specialized hospital teams to nonambulatory patients who prefer to remain at home as opposed to being institutionalized in a nursing or a hospital environment.

Adult day care centers would also serve as a vital alternative to institutional care for the older veteran. This type of service should provide an area for outpatient care including medical, rehabilitation, social, recreational, and health maintenance services to veterans who, because of these services, are able to live at home rather than be institutionalized in nursing homes or hospitals.

With the continued spiraling cost of medical and surgical care, enough cannot be voiced regarding the utilization of health maintenance programs similar to health care as offered by the health maintenance organizations (HMO) which would include, as an intrinsic part of these services, the delivery of preventive medicine. To ensure ultimate success, the Veterans Administration should be encouraged to enter into contractual agreements or affiliations with institutions of higher learning which specialize in nonmedical health care programs.

I am certain that this distinguished committee is aware that in January 1982, the Department of Medicine and Surgery of the Veterans Administration initiated a strategic planning process called the "Medical District Initiated Planning Program" (MEDIPP) to study at the "grassroot" level ways and means in which to direct the future of VA health care so as to meet the needs of a changing consumer.

I sincerely wish to compliment the Veterans Administration for implementing such a study group, and I am aware that a great deal of planning as to the future health care delivery has been prepared in writing and submitted to the Department of Medicine and Surgery of the Veterans Administration for review and evaluation by the Chief Medical Director. Unquestionably, many important projections will be made available, hopefully within the very near future.

I also want to compliment the Veterans Administration for the establishment of a new outpatient treatment clinic located in Crown Point, Indiana so as to enhance the delivery of health care to the veteran population in that area.

This concludes my presentation Mr. Chairman and again, thank you for the privilege of appearing before this committee.



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VAUGHAN CHAPTER

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CORRECTED COPY

STATEMENT OF
THOMAS A. DUNCAN, JR., PRESIDENT, CHAPTER DIRECTOR
VAUGHAN CHAPTER PARALYZED VETERANS OF AMERICA
BEFORE
THE HONORABLE ROBERT EDGAR, CHAIRMAN
SUB-COMMITTEE ON HOSPITALS AND HEALTH CARE
OF
THE HOUSE COMMITTEE ON VETERANS AFFAIRS
PERTAINING
TO HINES V.A. MEDICAL CENTER
HEALTH CARE DELIVERY TO IN-PATIENT AND OUT-PATIENT
JULY 7, 1983

Mr. Chairman and members of the Sub-Committee, Vaughan Chapter Paralyzed Veterans of America appreciate this opportunity to present its views on the health care delivery system here at Hines V.A. Medical Center. Vaughan Chapter is one of 35 member chapters of National PVA. As with all PVA members and chapters, we are veterans who have experienced spinal cord injury or dysfunction and due to that experience and dysfunction, we have considerable contact with Hines V.A. Medical Center Health Care System and the supplemental facilities and other extended medical health care services provided by the Veterans Administration.

Member of: Combined Veterans Association of Illinois • Veterans Assistance Commission • Illinois Independent Living Center, Inc. • National Center for a Barrier Free Environment • Rehabilitation International USA • United Buying Service • Illinois Jobs For Vets • National Spinal Cord Injury Foundation • CTA Advisory Board

a paraplegic is an individual.

The Paralyzed Veterans of America is a non profit organization dedicated to furthering the needs of the veteran, his dependent and all catastrophically disabled through service, education, medical research and the elimination of architectural barriers.

We will not concentrate on the Veterans Administration Health Care Delivery System in whole, since on March 16, 1983, a statement of National PVA was presented to the sub-committee on hospitals and health care in Washington D.C. I am sure you are well aware of that testimony and PVA's views in regard to medical construction program and the medical health care system in general.

Included in this testimony was specific problems and solutions to some of the issues that we will be discussing today. Therefore, in keeping with our National policy and in the interest of time and specificity, I will confine my remarks to the issues concerning the spinal cord injury health care delivery system here at Hines V.A. Medical Center.

There are seven issues which we wish to address in our text:

1. Long Term Care
2. Geriatric SCI Veterans
3. Personnel shortage, recruitment and retainment
4. Pharmacy: Medical supplies and medicine
5. SCI orientations
6. Female veterans
7. Medical School affiliation

Hines Spinal Cord Injury Service has a 135 bed capacity. The current daily bed census is 82. Understandably being one of the largest SCI Centers, there are many problems that are inherent because of this magnitude. However, some of the problems that had existed and are existing are being looked into and discussed by the administration here with PVA involved.

Over the years PVA-Vaughan Chapter has established a rapport with the Administration of the hospital and the Chief of Spinal Cord, a rapport whereby we can sit down and discuss any existing problems and attempt to find a viable solution.

Nonetheless, some of the problems that are existing today and some that have been resolved tentatively, have existed for over 30 years, around the time PVA was

incorporated here in Illinois as a Veterans Service Organization. At that time, an SCI veteran was not expected to live for any length of time. Fortunately, with the advancement in medical technology, some of those same SCI veterans are still living today. Thus in spite of the non-existence of a major war, the SCI veterans population has grown and according to the statistics that we have seen, it will continue to grow.

Therefore, we are faced with not only the young long term SCI veteran but the geriatric veteran as well.

The dilemma that was also created by the paternalistic attitude toward the SCI veteran has come back to be an albatross around the Veterans Administration neck and particularly this facility. We are faced now with a veterans population that has aged and is in need of long term care due to the fact that their spouses have gotten older and creating additional medical problems and no longer financially or physically able to take care of themselves. In the same vein, the paternalistic attitude fostered a rehab program that was geared to institutionalization rather than mainstreaming. Subsequently, we are faced with pushing forth crash programs to accommodate existing population and to insure that we do not create any more long term care SCI veterans.

It has been purported that some of the veterans are able to be gainfully employed and should not have been housed at a V.A. rehabilitation facility. This is difficult when a V.A. monetary benefit system states that when an individual is non-service connected and seeks employment and is attempting to mainstream himself will lose not only those monetary benefits but more importantly the medical support so necessary for sustaining and prolonging his life. As reported before by National PVA we have created a deterrent for total rehabilitation of a veteran whose very existence depends upon medical care available to him through the Veterans Administration. Moreover, this veteran is also hampered by the rules and regulations of the Social Security benefits that go against his attempt to mainstream. Therefore, not only do we have an aging population of long term veterans but we have a young non-service connected population that cannot be mainstreamed due to the laws governing the

eligibility for pension or social security. Consequently, we at PVA - Vaughan Chapter have for years been fighting for a solution. We have fostered the plans for a long term care domiciliary and fortunately through the cooperation of this medical administrator here at Hines, negotiations with National PVA and VACO, it seemed as if our goals were going to be realized. Plans were made for a long term care domiciliary to be constructed adjacent to the now existing Nursing Home Unit here on the grounds.

That left us with one problem what to do with some of the long term care veterans in the interim period, in order to free up those beds that may be needed for acute, medical and sustaining care. So more negotiations with the SCI Chief, Social Work Department and under the direction of the Hospital Director and a contract between the Deputy Medical Director, Dr. Earl Brown; a solution was reached, whereby up to 16 patients would be placed in the existing nursing home unit on a temporary basis until such time when a domiciliary would be built. At first we were against this, based on the fact of the economy and the many cut-backs in the V.A. programs. Because politically we had to consider the budgeting process that would occur once those veterans were removed from the SCI wards into the unit. Possibly, it would be decided that this would suffice and would appease and satisfy PVA and its members and influence the Administration and Congress to keep them there as an economical solution to the construction of the long term care domiciliary.

Although we have sat many hours with the administration of this hospital planning the long term care domiciliary we began to feel that this was to no avail, when we heard rumors about the cut-backs in construction.

Our suspicions were confirmed by a news release from the new Administrator, Mr. Walters and when we reviewed the list of construction to establish domiciliares, Hines was not included in this list. This can only lead us to believe that again the needs for a vehicle or prototype, in this case, a long term care domiciliary, staffed with those individuals specialized in rendering maintenance care to the SCI veteran, would not be realized. That in fact, Congress and the V.A., or both have failed to realize the need

for a long term care domiciliary geared to give specialized care to the aging, NSC, SCI veteran or any other SCI veteran who lacked the financial or physical capabilities to sustain himself outside of an institution. To further complicate what we felt was a viable solution to our problem we were promised seven trained staff to care for those veterans who were placed in the nursing home unit during the interim period. Several times we have approached the Director and the Nursing Director as to why this contractual arrangement has not been fulfilled. If we do not provide the care and the personnel to provide the care for the individuals in that unit we have defeated our purpose and that purpose is to provide the best possible medical care for the SCI Veteran. We must keep in mind that this veteran has a specialized disability that requires specialized care that will not cure him, that will not make him walk again, but will allow him an opportunity for a quality of life and a long life that he so richly deserves.

SOLUTION:

We come to you today, Gentlemen, and we present to you the following solutions:

1. To insure that the long term care domiciliary promised to this facility be built with all expediency and adequately staffed.
2. In the interim period, provide us with the funds to increase the staff or to add the staff necessary to sustain the individuals while they are in the existing nursing home unit.
3. To seek and provide other alternatives for the SCI long term care population.

We are well aware that a 40 bed unit will not resolve the problems of the aging and long term SCI veteran. However, as stated before, it will be a prototype, a training ground for the community for the construction or the re-organization of other facilities that may be utilized to take the strain off of the V.A. Medical Centers.

Surely, we must look at other alternatives. Some of those alternatives you have heard on a National level and we repeat them here because we have an opportunity

to see them work every day. Some of us sitting here before you are products of those solutions.

1. Increase and upgrade the hospital based home care system (HBHC).
2. Extend the fee based home health care program.

FVA supports the extended fee base home health care program. If anyone doubts the viability of this program, I suggest you look at the 1976 statistics upon the institution of the VA Health Care Omnibus Bill, which eliminated a lot of NSC veterans and reduced the amount of service that the service connected veterans could receive under the fee base program. Comparing them to the number of in-patients at that time as opposed to those who came into the system after the implementation of the act, you will see a significant increase after the latter.

These two programs combined allow the SCI veteran and all disabled veterans to maintain a viable home environment in the community and it would certainly enable those who are capable, to become gainfully employed, and therefore an asset to this society. With all this, Vaughan Chapter realizes that even these alternatives will not completely alleviate the problem of the SCI veteran at this point in time.

Accordingly, this medical facility recognized the need for a Community Nursing Home Committee. The tasks of this committee were as follows:

1. To establish a pre-discharge and post modern mechanism for the SCI veteran.
2. To determine accessibility both exterior and interior.
3. To pre-evaluate the administration staff in terms of patient care delivery, therapy, recreation and other like necessity for the care and maintenance of SCI veterans.

Secondly, a Residential Care Committee was formed. Their tasks were as follows:

1. Sponsor homes should have a shared family atmosphere.
2. Some mutually agreed upon house rules should exist in each home for sponsors and veterans to abide by.
3. To obtain a list of appropriate advertising newspapers in this area.

Whereas, FVA policy neither condones nor encourages nursing home placement, not

until they meet the required standards set by SCI personnel and approved by PVA. We do recognize the fact that if a facility is physically accessible and staffed with properly trained personnel who are capable of giving specialized care, that some nursing home placements may be successful. However, we are talking about individual adaptability and desire. Nevertheless, these programs will not be implemented in the near future. So in the meantime, let us caution you that this should be secondary and not preclude a VA long term care domiciliary and a viable VA-HBHC and Fee Base Program. With the institution and improvement of these programs there will be an example, or prototype if you will, from which those individuals in the community can develop the skills necessary for the continuing maintenance of the SCI aging and long term care veteran.

With this in mind, PVA - Vaughan Chapter has sat on both of these committees and have rendered which we consider valuable input as to the guidelines for the implementation of this program. At this point, I would like to thank this medical facility for their foresight and dedication to resolving the problem of the long term care and aging SCI veteran.

Just as we are sure that suitable nursing homes and residential care programs will not occur overnight, we must also be aware of the other needs of the aging population. This nation as a whole, is experiencing an increased population of geriatric individuals. Inclusive in this are the aging SCI veterans. Subsequently, with the onset of age we have seen an increase in fractures and breakage of bones that sometimes results in amputations. We have seen an increase of decubitis. We have seen an increase of respiratory difficulties. We have seen an increase in cardio-vascular disease etc.

Consequently, PVA - Vaughan Chapter would like to see an in-depth investigation as to why this is occurring and what can be done to avoid them. In spite of the fact that PVA produces an SCI Manual that depicts the necessity of skin care, we have seen the lack of emphasis in this area over the years. Patients are not given alcohol rubs as they were many years ago. Nor do they receive lotion or other oils

for skin care, that is necessary to prevent break-down, except if a doctor has ordered it. We have wondered whether or not it is because of lack of personnel, a lack of training, or even if it is on the part of the administration. Nonetheless, we would like to see an increase of skin care in this area. Vaughan Chapter also suggests that PT, OT and CT be increased for the aging and geriatric veterans. Often as not, once a veteran has been considered rehabilitated, and discharged from the hospital, or has reached maximum hospital benefits, and becomes long term, a lackadaisical attitude develops towards his need for physical activity. Again we find this somewhat contradictory when it is suggested by the medical profession that as age increases, physical activity must increase to prevent hardening of the arteries, breakage of bones and other pulmonary and cardio-vascular diseases.

We move on to personnel. For years, SCIS has always lacked an adequate amount of personnel and adequate trainer personnel. From our National testimony, you are aware that Physicians, RN's, and LPN's are greatly underpaid by the VA compared to the private sector. This does not offer an incentive for these individuals to remain in the system. We must look at the salary range of our health care professionals and make them commensurate with their counterparts in the private sector in order to offer incentives to remain in the V.A. Medical System. in addition to the Educational Programs.

Moreover, the SCI patient who is exposed to more nursing assistants than he is to Physicians, RN's, or LPN's, is subject to receive inadequate care due to the shortage of these individuals, not only in the nursing home unit, but on SCIS itself. It is a common practice amongst these individuals once they have been recruited and trained to SCIS to seek transfers to other units within the hospital or even other services who offer higher pay for less work or an opportunity for advancement. Vaughan Chapter proposes that hiring practices must be improved, recruitment techniques must be improved. The V.A. must offer paid scales comparable to those of private sectors. In addition to that, we must offer other gratuities for the retention of these individuals once they have been orientated to SCIS. Taking it one step further,

education, opportunities and opportunities for advancement should be offered to the individual. Thus we must offer incentives such as the upgrading and the change of title to SCI Nursing Specialists, along with grade and step increases. However, this is dependent upon whether or not the Nursing Director sees fit to hire Nursing Assistants to LPN's and RN's. Surely we realize that in this low economical period, and the nature of the job, that many times you can recruit individuals who are sub-standard in education or insensitive to the needs of the individual patients. Therefore, it may be necessary to make the criteria for acceptance into SCI Specialists more rigid.

However, if the Nursing Director decides that LPN's and RN's can provide the services that the SCI veteran health care needs, for his daily activities, then they must be educated to the fact that their duties will go beyond passing medication, dressings and the like. Since we are talking about bowel and bladder care, dressing and other personal hygiene necessities that most SCI veterans need from health care providers, RN's and LPN's are reluctant to perform these duties.

Our next area of concern is the lack of the knowledge within hospitals that is multi-disciplinary hospitals, when it comes to treating an SCI veteran outside of SCIS. Far too many times, we have experienced cases where an SCI veteran goes to another service for surgery or other medical care and returns with decubitis, bladder or other infections which could have been avoided if these individuals were orientated on how to care for the SCI veteran.

To compound this, we have witnessed discriminatory attitudes toward the SCI veteran because other individuals placed emphasis on his drug and alcohol problem. Vaughan Chapter admits that some drug and alcohol abuse exist and in the same vein it has questioned and suggested several times that a drug abuse and alcohol program for SCI veterans should be established. It has long been recognized that the SCI veteran drug and alcohol abuse, more often than not, are attributed to the ramifications of he or she becoming an SCI individual. In addition to his spinal cord

injury, it must be recognized that those individuals who have a drug abuse or alcohol abuse problem are indeed in need of professional help in this area.

Edward J. Hines Medical Center has, in conjunction with PVA, conducted several seminars designed to educate, both the community and in-house personnel as to the ramifications of SCI from the acute stage through placement back into the community. These multi-disciplinary projects comprised of in-house personnel, has proven to be somewhat successful. We of Vaughan Chapter - PVA would like to see and indeed support more of such seminars to dispel this stereotyping and the unavoidable discriminatory practice against the SCI veteran.

Further, the lack of knowledge of the SCI veterans needs and the ramifications of his injury has overflowed into the pharmaceutical department. Although an out-patient nurse coordinator has been established on the SCIS to monitor and provide the SCI out-patient with the technical and medical assistance and referrals necessary,

to maintain himself outside the system. It goes array when an individual cannot obtain the necessary medical equipment, supplies or medicine.

The SCI patient requires specialized equipment, medicines and supplies on an on-going basis germane to his injury that are not common to the other types of disabled veterans within the medical system. The timely delivery of such items as catheters, external catheters and other life supporting supplies and medicine is paramount for the day to day existence of this veteran.

Too often the veteran has to wait beyond the exhaustion of those items before they have been refilled and moreover, he does not receive an adequate amount of the items to sustain him until the next authorized refill period. This can be attributed to the lack of knowledge of those medical items necessary for the sustaining of this individual outside an institution. The nurse practitioner has worked very well with the pharmacy in trying to alleviate this lack of knowledge. However, with the turnover of personnel in that area or apathy on their part, we are still experiencing these problems. I can only state that this is due to budgetary restraints imposed

by the Congress.....and therefore, we must take a look at the system to make sure that all class of veterans are treated equally according to the individual needs.

In the same vein we at PVA, along with the nurse practitioner, have and will continue to encourage the SCI veterans not to abuse the system. That is the reason why we sat as representatives on the Equipment Committee, the Steering Committee, and other committees related to delivery of supplies, equipment and medicine.

Next to last but of course not the least is the problem of the female SCI veteran. In the past, this worthy individual was passed off to other private sector hospitals or affiliated medical facilities. However, as statistics have shown there has been a marked increase not only in the female veteran coming into the VA system but the SCI female veteran coming into the VA system. We can expect with the increase of women enlisting in the service, an increase in leisure time, which fosters these injuries, more female veterans in our medical system. We must provide a mechanism by which we can render her adequate and equivalent care.

Finally, we must address some problems we feel exist with the medical school affiliations. This is a well thought out and well needed program that was instituted by the Veterans Administration. However, in this time of economical crunch and budget cuts, we must carefully monitor privilege abuses that may be forthcoming from our affiliates. We realize it is necessary for our facility to be used by medical affiliators. However, we have witnessed occasions where students have abused the use of the facility which inevitably increased the overhead cost and distorts any budgetary controls or planning by the VA. At this point, we cannot point the finger nor will we point the finger at any certain individual. We are only asking that this association of medical schools be carefully scrutinized to assure that the privileges afforded their affiliation are not abusing and escalating the VA budget. Furthermore, our generousities for the use of our facilities should be reciprocal in our time of need. Mr. Chairman and other members of the committee, guests, I want to thank you for taking time out to listen to this testimony, to come and make an on-site visit in order to understand the problems that we are experiencing and to set priorities during the on-going budgetary process.

This is, unquestionably, a dedication to providing quality care to the veteran.

In conclusion, I would like to express to this body that we have experienced and will continue to experience a good working relationship with the administration of this medical facility. Though we may not always agree we somehow succeed to manage our conflicts and make the proper decisions for the betterment of all the veterans. To this end we will continue to work but we would like to leave you with this thought, it does not matter how many solutions and alternatives that we develop here in the field, it cannot be resolved unless we are authorized by the VA Central Office and properly funded by the United States Congress to carry out our programs. The obligation that we have to veterans is one that we must all share and that we must all be held responsible for if we waiver from that obligation. Mr. Chairman and members of the sub-committee, this concludes my statement on behalf of Vaughan Chapter PVA and I will be glad to answer any questions you may have.



Department of Illinois



For God and Country

VETERANS AFFAIRS AND REHABILITATION
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July 6, 1983

Mr. Bob Edgar, Chairman
Subcommittee on Hospitals
and Health Care

RE: Review of In/Out Patient Veterans Administration Health Care

To the Members of the Subcommittee:

I wish to thank you for allowing The American Legion, Department of Illinois to testify before this Subcommittee on V.A. Health Care.

In Illinois, we have a total of 1,498,000 veterans. Out of this amount, 737,190 are from the metropolitan area of Chicago and Cook County. These veterans are serviced at three V.A. Hospitals within the area: Hines, Westside, and Lakeside. The amount of veterans increases if we include the collar counties and North Chicago V.A. Medical Center.

Due to the economy, veterans of all ages are asking assistance from the V.A. I feel that the heaviest influx of the veterans are the World War II and Korean-conflict veterans. The average age of these veterans is between 50 - 64 years of age. These people are too young for Medicaid, Medicare, or Social Security benefits. Most are either without jobs or are seeking work. In the meantime, they have no hospitalization. In the case of a family on Public Aid; the dependents will receive medical care, but if one or both of the parents are veterans, they will be directed to the V.A. for medical treatment.

It is a known fact that the veterans of this country are getting older and will be needing more medical attention. I do not feel that the V.A. has the funds to treat these veterans. The budget will have to be reviewed and more money made available for services to the veteran.

At this point, a veteran will go to a V.A. Hospital for treatment, will be examined by a doctor, and possibly given medication. After 30 days, the veteran will be asked to go to his private doctor. Most of them would go to a private doctor, but in view of the above-mentioned reasons, these people do not have hospitalization benefits. Considering the older veteran

**MEMBERSHIP IN THE AMERICAN LEGION HELPS MAKE
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ARE YOU A MEMBER?

25-147 252

who is receiving Medicare or Medicaid, we are still seeing a majority who cannot afford the cost of a private doctor because of federal cut-backs to their benefits.

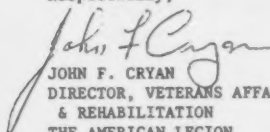
At Westside V.A. Medical Center, they are filling an average of 10,000 prescriptions a week. They are also getting an average of 463 new in-patients a month. These benefits all cost money and that is what we must fight for to give adequate care. I know that the monies allocated to the V.A. are greater than the year before. The percentage is less because the increase of benefits needed for older veterans is growing more rapidly. At this point, we are receiving 3 percent of the budget. There are some brighter directions. We now have Medipp and there is future expectations towards geriatrics. But the fact of the matter is - the future is now. We must review the budget and take all of these facts into consideration.

It is my personal opinion that the V.A. Hospitals are doing everything possible to help these veterans. Considering their resources, I would say they are doing a great job. I would like to summarize these facts and our views by relating a question that was asked of me. At one of the medical centers, a veteran who was in the waiting room reading a newspaper stopped me to tell me he had been a combat veteran in both World War I and World War II. He was just then reading of how the United States sends money to Central America and many other countries around the world. Millions and millions of dollars are given to the economies of these countries to give their people human rights and dignity. The veteran said he felt these gestures were good, but what about the human rights and dignity of the American veteran. The budget for our needs and care is less every year and yet our overseas assistance increases. "I always believed charity began at home," he stated. "We have gone to fight wars, given most of our younger years, and many people have given their lives. But now that we are getting older and need more help, our Government cannot take care of us."

The V.A.'s system was built and put into being for the benefit of the American veteran. This is the soul entity of the V.A. - to take care of those who served; and yet we are not funded to do so. Why? Do you have the answer? I certainly don't. I couldn't answer the veteran who asked. I don't know whether the Subcommittee can find the answer.

I would like to thank all of the members of the Subcommittee for taking the time to hear our views and concerns, and add that I personally am acquainted with many of the Director's at the V.A. Hospitals and the work they accomplish. They are doing everything possible with the resources they have to service our veterans. While they are doing a wonderful job, it saddens me to say that they could do a better job if they funds were better allocated to care for our veterans.

Respectfully,


JOHN F. CRYAN
DIRECTOR, VETERANS AFFAIRS
& REHABILITATION
THE AMERICAN LEGION
DEPT. OF ILLINOIS

AMVETS

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Department of Illinois

OFFICE OF THE STATE SERVICE DIRECTOR

June 27, 1983

TO: Mr. Bob Edgar,
Chairman, Subcommittee on Hospitals & Health Care.

REGARDING: Review inpatients & outpatients V.A. Health Care.

Members of the Subcommittee:

Thank you for allowing AMVETS to testify before this subcommittee on hospitals and health care for our veterans in V.A. hospitals.

It is becoming very apparent in dealing with the V.A. hospitals in the Chicago Area are quite concerned over the lack of health services promised to all our veterans in the V.A. hospitals.

Regardless of the type of disability, service connected, or non-service connected, treatment must be available to the eligible veterans who seek help in a V.A. hospital.

World War II veterans are requesting admission in great numbers due to the economic conditions many veterans of all ages are requesting admission to V.A. hospitals.

Unemployment and with the loss of hospital insurance coverage has forced these veterans to seek admission to a V.A. hospital. It is

becoming quite apparent due to the heavy work load of patients, the V.A. hospitals are severely short of funds to handle the overload.

The V.A. hospitals were prepared for the World War II veterans, but all veterans seeking admission has caused this problem.

When a veteran who served for his country, the government promised hospital and health care for him, this promise must be kept.

Another situation is Medicare and Medicaid cut backs causing many veterans to go to V.A. hospitals for treatment. Non-service connected veterans seeking medical attention are given 30 days medication, and told to go to their private doctors for assistance. The service connected veterans, seeking non-service connected treatment is also being told to go to their private physicians.

The V.A. hospital Pharmacy Units at West Side V.A.M.C. and Hines V.A.M.C. are filling out over 12,000 prescriptions per week and increasing in volume. This gives you an idea of the work load.

In closing, fund must be provided to the V.A. Medical Centers to be able to give this Health Care to the deserving veterans as promised by Congress.

I personally feel the V.A. hospitals are doing everything possible to help the veterans. The answer is money.

Thank you,

A. J. ... A. P. ...
Illinois AMVETS

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American Ex-Prisoners of War, Inc.

CONGRESSIONALLY CHARTERED
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7-8-83
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Hon. Robert Edgar
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Dear Sir;

I am Harold F. Sheahan State Service Officer and Past National Director of the American Ex-Prisoners of War, who attended your hearing on Hospitals and Health care at Hines Hosp. July 7th.

I asked the question from the floor after the hearing had ended. "Why the American Ex-Prisoners of War were not invited to participate with the other Service Organizations?" You stated that it was an oversight and not intentional and I may include a statement as a record of the hearing. There is so much to be learned by the Veterans Administration regarding PL.97-37 that I was amazed that we were ignored. Not one of the Service Officers nor any of the four V.A. Administrators included in their reports anything regarding PL.97-37. For the record Mr Fears of Hines Hospital has provided us an office with the other Service Officers and his staff is cooperating with us as well as can be expected. We do, however, find that there is a lack of information and instructions through out the hospital on the interpretation of PL.97-37. We have many complaints at the personnel and admittance level, which leads me to plead for an Administration directive to be sent to all departments explaining the Law pertaining the Ex-POW.

This statement in no way is a condemnation of Mr. Fears nor his staff but an urging to have PL.97-37 carried out in all V.A. installations in the Chicago Area.

I am sending a copy of this letter to my Congressman George M. O'Brien and Tom Corcoran and Senator Charles H. Percy. I wish to thank you for the opportunity to include my statement and hope in the future that you will have the American Ex-POWs. included at your hearings. I would appreciate a reply at your earliest convenience. I remain

an Ex-POW

Harold F. Sheahan
Harold F. Sheahan P.N.D.

WE EXIST TO HELP THE MAN WHO CANNOT HELP HIMSELF.